

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
FRANCIS		C.	ALLEN		Month 5 Day 5 Year 68		1:00 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE	NEGRO		10/9/21		46 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VET. ADM. HOSPITAL		LABORER		PAPER CUP CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		722 N. Avondale Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
unknown		Gertrude Allen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES		WW II		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS									
150x DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
150x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 3/10/68, 19, to 5/5/68, 19, that (X) (we) last saw the deceased alive on 5/5/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
John D. Talbert, M.D.								5/6/68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS	
JOHN D. TALBERT, M. D.								VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5-9-68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Mary O. W. Lewis		WILSON FUNERAL HOME		DATE MAY 9 1968		f Charles Judge			
		2004 Orleans St. Baltimore, Md.							

1120

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)
30th REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last CLARICE OTT ALLEY			2a. DATE OF DEATH Month Day Year MAY 4, 1968		2b. HOUR 1: M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 9 NOV. 1899		6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) TENN.	7b. CITIZEN OF WHAT COUNTRY? U.S.-A	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH DUNDALK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3434 YORKWAY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PRACTICAL NURSE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN DUNDALK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last WALTER S. OTT		15. MOTHER'S MAIDEN NAME First Middle Last BETTIE — DRAKIE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) (If yes give war or dates of service) NO	
16b. SOCIAL SECURITY NO. 411-14-5996		17. INFORMANT Address MARY E. ASKEW - DAUGHTER AS IN #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1958, to May, 1968, that (I) (we) last saw the deceased alive on May 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. W. SOLLOD				22c. DATE SIGNED 5-6-68	
22d. PHYSICIAN'S NAME (Type) B.W. SOLLOD				22e. ADDRESS 2900 DUNNAN RD. DUNDALK, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-7-1968	23c. NAME OF CEMETERY OR CREMATORY GARDENS FAITH		23d. LOCATION (City or Town) (County) (State) BALTIMORE CO. Md
24. FUNERAL DIRECTOR W. Burke Bradley, Dundalk, Md.			25a. REC'D BY REGISTRAR DATE MAY 8 1968		25b. REGISTRAR'S SIGNATURE

00578

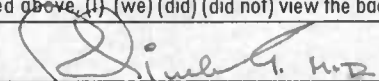
00578

CHURCH OF THE HOLY TRINITY
1000 10th St. N.W.
Washington, D.C. 20004
Telephone: 222-1234
Fax: 222-5678
E-mail: info@churchofthetrt.org
Web: www.churchofthetrt.org
The Church of the Holy Trinity
is a member of the American
Orthodox Church in America.
We welcome all to our services.
Sunday, 10:00 AM
Divine Liturgy
and Holy Communion
in English and Russian.
For more information,
please contact our priest,
Fr. George K. Gerasimov,
at 222-1234.

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VR A15 (4)
30M REV. 1-68

<div style="text-align: center;"> 06579 <div style="display: flex; justify-content: space-between;"> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 </div> <div> CERTIFICATE OF DEATH </div> <div> 06579 </div> </div> </div>																	
1. DECEASED-NAME (Type or print)			First MARY			Middle ALT			Last ALT			2a. DATE OF DEATH Month MAY Day 16 Year 1968			2b. HOUR 5:45 A.M.		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH JANUARY 3, 1888			6. AGE (In years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE, Md.								
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY Balto.			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2425 WELLBRIDGE DR. APT. F					
14. FATHER'S NAME First John			Middle A.			Last Dauses			15. MOTHER'S MAIDEN NAME First Kunigunda			Middle Deerbeck			Last Deerbeck		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No			16b. SOCIAL SECURITY NO. 273-07-7853B			17. INFORMANT Address Mrs. Anna Wagner, 1641 Waverly Way #21212											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism 450x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 465x (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 23, 1968 to MAY 16, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED May 16, 1968								
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/18/68.			23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.								
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 17 1968			25b. REGISTRAR'S SIGNATURE 								

1533

Journal of Management Education

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VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First Middle Last				20. DATE OF DEATH				2b. HOUR	
Vincent				AMBROSE				Month Day Year May 10, 1968				3:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		May 10, 1968				YRS.		5		32	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U.S.A.				Baltimore, Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Towson		ST. JOSEPH HOSPITAL				N/A							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Balto.		Baldwin				Langshire Rd.					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Vincent William Ambrose				Katherine Dorothy Chapman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No (unknown)				None		Mr. Vincent W. Ambrose (Same)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Immaturity													
7761 DUE TO, OR AS A CONSEQUENCE OF Hyaline Membrane disease													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
7735													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (this hospital) attended the deceased from 5/10/1968, to 5/10/1968, that (X) (we) last saw the deceased alive on 5/10/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Imelda Salanio								22c. DATE SIGNED May 10, 1968					
22d. PHYSICIAN'S NAME (Type) Imelda Salanio, M.D.								22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		5/11/68.		St. John's Cemetery		Long Green, Md.							
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck, Inc. Balto Md. 21214				DATE MAY 13 1968		Charles Judge							

81-11487

523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Harry Curtis Amoss						Month Day Year			3:25 p. M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
male		white		Feb. 7, 1877			91 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U. S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			SPRING GROVE STATE HOSP.			dairy route			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		HEBESVILLE Gwynn Oak		YES		2206 Pine Avenue
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Alfred Amoss									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			219-54-3003JL		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death									1 day
4109 DUE TO, OR AS A CONSEQUENCE OF with Right Bundle Branch Block									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201									
(b) Atherosclerotic Cardiovascular Ht. Dis.									4 years.
DUE TO, OR AS A CONSEQUENCE OF									
(c) Arteriosclerosis, Generalized, Senile									10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) c) RLL Pneumonia									
a) Obesity, exogenous; b) Left Lower Lobe Pneumonia, Mar.'68, Imp.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (X) (this hospital) attended the deceased from Feb. 26, 1964, to May 16, 1968, that (X) (we) last saw the deceased alive on May 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
[Signature]								5-16-68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS	
Anthony J. Young, M.D.								SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		May 20 '68		MOUNT VIEW		CARROLL COUNTY		MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Stansbury Funeral Home		4411 WindSOR mink Rd.		DATE MAY 20 1968		[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 578
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
06582

1. DECEASED-NAME (Type or print) CHARLES E. ASTROP			2a. DATE OF DEATH Month 5 Day 24 Year 1968			2b. HOUR 11:10AM			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 10/26/98		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done) LABORER, TRUCK OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY STEEL CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 130 CHESTNUT STREET	
14. FATHER'S NAME First TOM Middle ASTROP Last ASTROP			15. MOTHER'S MAIDEN NAME First HATTIE Middle EVANS Last EVANS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give year or dates of service) WW I		16b. SOCIAL SECURITY NO. 228 03 87 13		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200 (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from 2/13/68 , 19__, to 5/24/68 , 19__, that he (we) lost saw the deceased alive on 5/24/68 , 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (we) (did) (do not) view the body after death.									
22b. SIGNATURE Kurt Raab DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 5/24/68	
22d. PHYSICIAN'S NAME (Type) KURT RAAB, M. D.				22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-28-68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR Charles R. Law ADDRESS CHARLES R. LAW FUNERAL HOME Madison Ave. Baltimore, Md.				25a. REC'D BY REGISTRAR MAY 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CONSENT

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Figure 1

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THE NATIONAL TV, RADIO & TELEPHONE CO., LONDON. AND 1175 CO. 552

ANALYST: [REDACTED] DATE: [REDACTED]

THE JOURNAL OF THE

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11. *U. rubra* (L.) (Fig. 11)

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U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 514
30M REV. 1-28

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|---|---|--|--|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| Item # 7b, Film # G401 5/31/68 km | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 06579 | | | | | | | | | |
| 06583 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Peter | | | First Middle Last | | | 2a. DATE OF DEATH
Month 5 Day 24 Year 68 | | | 2b. HOUR
11 P.M. |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
4-23-1892 | | 6. AGE (In years last birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Greece | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTO Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Balto. Med. Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired Rst. Owner | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2916 HILLCREST. | |
| 14. FATHER'S NAME
First Middle Last
James Athas | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Georgia K. Knowl. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
217-18-9098 | | 17. INFORMANT
Mr. James Athas | | 17. ADDRESS
112 Malbrook Rd. #29 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
433.9
DUE TO, OR AS A CONSEQUENCE OF
Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
332X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 68 , to 5-24 , 19 68 , that (I) (we) last saw the deceased alive on 5-24 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Lilia C. Baldonado | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-24-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
LILIA C. BALDONADO | | | | 22e. ADDRESS
Game | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/28/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Greek Ortho. Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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00330

Inter

Adrian

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1-23-12

White

Male

Barto

X

Greene

Greater Barto Hills Center

Marshall

Barto

X

Adrian

James

1-23-12

General

Bartholomew



Bartholomew
Lila C. Bartholomew

Barto

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | |
|--|--|------------------------------|--|--|------------------------------------|---|---------------------------------|--|---|------------------------------|--|--|
| Howard | | | | | | Baetjer | Month | Day | Year | CA M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| M | | W | | Dec. 20, 1879 | | | 88 YRS. | | MONTHS | DAYS | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Balto. Md. | | U. S. A. | | | | Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Stevenson | | | Valley Rd. & Park Heights Ave. | | | President-Textiles -Mt. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | | Balto. | | Stevenson | | YES | | Valley Rd. & Pk. Heights Ave | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | |
| John | | | | G. | Baetjer | Mary | | | | | Koppleman | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| Yes | | | | WWI | | 212-10-7096 | | | H. Norman Baetjer, Jr. Garrison, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | 7 or more years | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 4200 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>65</u> , to <u>May 1</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>30 Apr</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| Paul H Royse M.D. | | | | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | May 1 1968 | | | |
| Dr. Paul H. Royse | | | | | | 1403 Foley Lane | | | Balt. Md 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 5/3/68 | | Greenmount | | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | | MAY 3 1968 | | | Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06581

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06585

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|----------|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print)
Christine M. Baumbach | | | First Middle Last | | | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5/19 19 68 4 15 PM | | | 2b. HOUR | | | | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
9/5/1885 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month May Day 19 Year 1968 4 15 PM | | 2d. HOUR | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Woodlawn | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2300 Poplar Drive | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)
None | | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Woodlawn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2300 Poplar Drive | | | | | | | | | | | |
| 14. FATHER'S NAME
Frank Knell | | | | | | 15. MOTHER'S MAIDEN NAME
Anna Regar | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO.
217-48-7589 | | 17. INFORMANT
William F. Barmback | | | | | | ADDRESS
2300 Poplar Drive | | | | | | | | | |
| MEDICAL CERTIFICATION
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular disease
4/29 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
42271 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden | | | | | | | | | |
| | | | | | | | | | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | | | | | | 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE James N. Frederick
EXAMINER'S NAME (Type) James N. Frederick | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) 1311 Francis Ave Baltimore, MD 21227 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
J. T. Stansbury 6411 Windsor Mill | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | |

00581

00582

MEDICAL EXAMINER'S REPORT

REPORT OF THE MEDICAL EXAMINER

| | | | |
|--------------------------------|--|----------------------------------|--|
| Name of Deceased | | Date of Death | |
| Place of Death | | Cause of Death | |
| Manner of Death | | Disease or Injury | |
| Age of Deceased | | Sex of Deceased | |
| Race of Deceased | | Occupation of Deceased | |
| Marital Status of Deceased | | Social History of Deceased | |
| Medical History of Deceased | | Physical Examination of Deceased | |
| Mental Examination of Deceased | | Toxicology of Deceased | |
| Autopsy of Deceased | | Disposition of Body | |
| Signature of Medical Examiner | | Signature of Coroner | |
| Date of Report | | Time of Report | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 06582 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06586 | | | | | | | | |
|--|--|--|--|--|--------------|---|-----------------|--|-------------------------------------|---|--|--|----------------|---|-------------------|--|------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
DEBORAH | | Middle
JO | | Last
BAUMOEL | | | 20. DATE KNOWN OF ESTI-DEATH MATED
<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year
May 18, 1968 | | 2b. HOUR
7:45 ^a _M | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
SEPT. 10, 1951 | | 6. AGE (In years last birthday)
16 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month May Day 18, Year 1968 | | 2d. HOUR
7:45 ^a _M | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
VIRGINIA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | |
| 1d. CITY OR TOWN OF DEATH
BALTIMORE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Apt. 815 Balmoral Apt. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
STUDENT | | | | 12b. KIND OF BUSINESS OR INDUSTRY
SCHOOL | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia | | | | 13b. COUNTY
Roanoke | | 13c. CITY OR TOWN
Roanoke | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2142 Pellham Drive | | | | | | | | |
| 14. FATHER'S NAME | | | First
WALTER | | Middle
J. | | Last
BAUMOEL | | | 15. MOTHER'S MAIDEN NAME | | | First
EULAH | | Middle
JOHNSON | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | | | (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
WALTER J. BAUMOEL | | | | ADDRESS
2142 PELLHAM DR.
ROANOKE, VA. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Epilepsy
3459
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
3533 | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 2d. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M.
19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Edward F. Wilson | | | | M.D.
Edward F. Wilson, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
May 18, 1968 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
MAY 21, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
TEMPLE EMANUEL | | | | 23d. LOCATION (City or Town) (County) (State)
ROANOKE VA. | | | | | | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BRAS. | | | | ADDRESS
6010 REISTERSTOWN RD
BALTIMORE, MD. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

00288

00288

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is to determine the effect of temperature on the rate of reaction of hydrogen peroxide with potassium iodate. The organization of the project is as follows: Introduction, Materials and Methods, Results, Discussion, and Conclusion.

2. The second part of the report is a description of the materials and methods used in the experiment. It includes the list of materials, the list of equipment, and the description of the experimental procedure. The materials used are hydrogen peroxide, potassium iodate, and sulfuric acid. The equipment used is a thermometer, a stopwatch, and a graduated cylinder. The experimental procedure is as follows: A solution of potassium iodate is prepared in a beaker. A solution of hydrogen peroxide is added to the beaker. The temperature of the solution is measured. The time taken for the reaction to occur is measured. The rate of reaction is determined by the time taken for the reaction to occur.

3. The third part of the report is a description of the results of the experiment. It includes the data obtained from the experiment and the graphs plotted from the data. The data obtained from the experiment is as follows:

| Temperature (°C) | Time taken for reaction to occur (s) |
|------------------|--------------------------------------|
| 20 | 120 |
| 30 | 60 |
| 40 | 30 |
| 50 | 15 |

The graphs plotted from the data are as follows:

Graph 1: A plot of the rate of reaction (1/time) versus temperature. The rate of reaction increases with temperature.

Graph 2: A plot of the natural logarithm of the rate of reaction (ln(1/time)) versus temperature. The plot is a straight line, indicating that the reaction is first order with respect to temperature.

4. The fourth part of the report is a discussion of the results of the experiment. It includes a comparison of the results with the theoretical predictions and a discussion of the factors that affect the rate of reaction. The results of the experiment are in good agreement with the theoretical predictions. The factors that affect the rate of reaction are temperature, concentration, and surface area.

5. The fifth part of the report is a conclusion. It summarizes the results of the experiment and states the main findings. The main findings are that the rate of reaction increases with temperature and that the reaction is first order with respect to temperature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon patient register and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 06588 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06587 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) <u>Lillian Myrtle</u> <u>Bazemore</u> | | | | | | 2a. DATE OF DEATH <u>3</u> <u>13</u> <u>68</u> | | 2b. HOUR <u>9:15</u> <u>AM</u> | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>CAU</u> | | 5. DATE OF BIRTH <u>3/26/96</u> | | 6. AGE (In years lost birthday) <u>72</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Baltimore</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore, Md</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Greater Baltimore Med. Center</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RETIRED</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>TOWSON</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <u>600 PARK LANE</u> | | | |
| 14. FATHER'S NAME First <u>Steven</u> Middle <u>Gillikin</u> Last <u>Willis</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Willis</u> Middle <u>Willis</u> Last <u>Willis</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>243-01-562</u> | | 17. INFORMANT <u>Patient's Chart</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> | | | | | | | | | | | |
| (c) <u>Cerebral Vascular Accident</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4341</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>68</u> , to <u>5/13</u> , 19 <u>68</u> , that (a) (we) last saw the deceased alive on <u>5/13</u> , 19 <u>68</u> , and that in (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Keiffer Mitchell</u> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>5/13/68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>KEIFFER MITCHELL MD</u> | | 22e. ADDRESS <u>6701 N. Charles St. #21204 Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>May 15, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Pine View Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Rocky Mount, North Carolina</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR <u>DATE MAY 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

4290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|---|-------------------------|--|---|---|
| 1. DECEASED-NAME
(Type or print) EMMA CATHERINE BEELEN | | 20. DATE OF DEATH
Month May Day 11 Year 1968 | | 2b. HOUR
3:15 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Sept. 17, 1888 | | 6. AGE (In years last birthday)
79 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First Middle Last
Goettlieb Gottlieb Hanf | | 15. MOTHER'S MAIDEN NAME First Middle Last
Johanna Dietz | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
213-48-0474 | | 17. INFORMANT
daughter Address
Gloria Noonan, 3627 Erdman Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undifferentiated carcinoma of the lung
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
163X | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-30 , 19 68 , to 5-11 , 19 68 , that (I) (we) last saw the deceased alive on 5-11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Camilo Z. Tomboc DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5-11-68 |
| 22d. PHYSICIAN'S NAME (Type)
Camilio Z. Tomboc, M.D. | | | | 22e. ADDRESS
7620 York Road, Baltimore, Md. 21204 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/14/68 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | |
| 23d. LOCATION (City or Town)
Baltimore, Md. | | (County) (State) | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

00588

00588

UNITED STATES OF AMERICA

January 1973

GEORGE H. BROWN, JR.

January 1973

UNITED STATES OF AMERICA

January 1973

GEORGE H. BROWN, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--------------------------|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| DANIEL | | | RUFUS | BELL | Month Day Year
MAY 5, 1968 | | | 9:45AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| MALE | | NEGRO | | 1/11/10 | | 58 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| VIRGINIA | | U.S.A. | | | | BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| FORT HOWARD | | VETERANS ADMIN. HOSPITAL | | CHECKER | | STEEL | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | | BALTIMORE | | | | 2640 CECIL AVENUE | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| JAMES | | | - - | BELL | MANDA | - - | | | JARVIS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address |
| YES | | | WWII | | 214 07 99 35 | | | | CLINICAL RECORDS, VAH, FT. HOWARD, MD. |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CANCER OF THE PROSTATE</u>
<u>185X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (o),
stating the underlying cause
lost. <u>171X</u>
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>MONTHS</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)
<u>METASTASIS TO SPINE AND LUNGS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | 22a. I certify that it (this hospital) attended the deceased from <u>NOV 24</u> , 19 <u>67</u> , to <u>MAY 5</u> , 19 <u>68</u> , that it (we) last
saw the deceased alive on <u>MAY 5</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the
causes stated above, it (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Conrado L. Mancao, M.D.</u> DEGREE | | | | | ATTENDING
PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>5/5/68</u> | | |
| 22d. PHYSICIAN'S
NAME (Type)
CONRADO L. MANCAO, M.D. | | | | | 22e. ADDRESS
VAH, FT. HOWARD, MD. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (city) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-9-68 | | BALTO. NATIONAL CEMETERY | | BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
1701 LAURENS ST.
MORTON & DYETT FUNERAL HOME BALTO., MD. | | | | | 25a. FILED BY REGISTRAR
DATE
MAY 7 1968 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

0883

0883

DATE: 10/1/50 TIME: 10:00 AM

TO: MR. J. EDGAR HOOVER

FROM: MR. J. EDGAR HOOVER

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: 10/1/50

TIME: 10:00 AM

TO: MR. J. EDGAR HOOVER

FROM: MR. J. EDGAR HOOVER

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: 10/1/50

TIME: 10:00 AM

TO: MR. J. EDGAR HOOVER

FROM: MR. J. EDGAR HOOVER

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: 10/1/50

TIME: 10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 06586 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | 06590 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Margaret Evelyn Bell | | | 2a. DATE OF DEATH
Month Day Year
May 12, 1968 | | | 2b. HOUR
10:10 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Feb. 21, 1904 | | 6. AGE (In years
last birthday)
64 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore, 21207 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
5223 Pembroke Ave. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
receptionist | | 12b. KIND OF BUSINESS OR
INDUSTRY
Staceys Dist | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Mi. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore 7 | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
Edgar O. Dix | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Ellis Minis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, aa, or unknown) (If yes give war or dates of service)
NO none | | 16b. SOCIAL SECURITY NO.
217-05-3531 | | 17. INFORMANT
Address Baltimore 7, Md.
Mrs. Carole Lee Wunder, 5223 Pembroke Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatosis</u>
<u>174X</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of Breast</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>about 2 years</u>
<u>12 years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>170X</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>May 12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Julius C. Gluck, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Julius C. Gluck, M.D. | | 22e. ADDRESS
5356 Reisterstown Rd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
<u>Frank H. Newell, Baltimore</u> ADDRESS | | | | 25a. REC'D BY REGISTRAR
MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

3235

한글서체

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 06587 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06591 </div> | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | 2a. DATE OF DEATH | | 2b. HOUR |
| Richard W. Bell | | | | | | | May Month 18 Day 1968 Year | | 7:40 A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| male | | white | | Dec. 10, 1874 | | 93 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md. | | U. S. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | Carpenter Ret. | | Simpson Co. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | | Balto. | | Perry Hall | | 8925 Parlo Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Samuel Bell | | | Anna Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | | | 212-07-0921 I | | Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | | Days |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stimulity</u> | | | | | | | | | Years - |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 493X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 14, 1968, to May 18, 1968, that (I) (we) lost saw the deceased alive on May 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE George Rodon M.D. | | | | | DEGREE ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5-18-68 |
| 22d. PHYSICIAN'S NAME (Type) George Rodon | | | | | 22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-21-1968 | | Baltimore Cemetery | | Baltimore City Md. | | | |
| 24. FUNERAL DIRECTOR Address | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Joseph H. 7401 Brian Rd. | | | | | MAY 22 1968 | | Charles Judge | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item #5 Film #G400 5/20/68 ph

06592

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
FLORENCE G. BENNETT | | | 2a. DATE OF DEATH
Month Day Year
May 13, 1968 | | | 2b. HOUR
12:15 M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1893
May 8, 1893 | | 6. AGE (In years
last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Essex (21) | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
902 Virginia Ave. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
902 Virginia Avenue | |
| 14. FATHER'S NAME First Middle Last
Thomas Harrison | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Catherine Akern | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
214 01 9387D | | 17. INFORMANT
William Bennett | | Address
Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>
<u>4129</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DYS.</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 DAY</u>
<u>6 YRS</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>4221</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APR 15 1968</u> , to <u>MAY 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>MAY 12 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph Miceli MD</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/13/68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
Joseph Miceli, M.D. | | | | 22e. ADDRESS
108 S. Taylor Ave. Baltimore, Md. 21221 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
<u>Bruzdinski Funeral Home</u> | | | | ADDRESS
1407 Eastern Ave. | | 25a. REC'D BY REGISTRAR
DATE
MAY 16 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEDICAL CERTIFICATION

X

306

3330

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06582

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06594

| | | | | | | | | |
|---|--|--|---|---|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) LAUREN M. FORD BEYARD | | | 2a. DATE KNOWN OF DEATH
ESTIMATED MAY 30 1968 | | | 2b. HOUR M | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
1-28-24 | 6. AGE (in years last birthday)
44 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month MAY Day 30 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BATIMORE | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)
Electronics Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Westinghouse |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN
TIMONIUM | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
20 AYLESBURY RD. | |
| 14. FATHER'S NAME
First Albert Middle Blair Last Beyard | | | | 15. MOTHER'S MAIDEN NAME
First Alma Middle Klingaman Last Klingaman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) yes | | | 16b. SOCIAL SECURITY NO.
220-18-0841 | | 17. INFORMANT
Family records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE William A. Pillsbury | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 5-30-68 | | |
| EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) Towson, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/1/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Memorial | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville Md. | | |
| 24. FUNERAL DIRECTOR
John Burns Sons | | | | ADDRESS
Towson, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

03334

03330

RECEIVED
JUN 10 1964



UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250
JUN 10 1964
OFFICE OF THE SECRETARY
WASHINGTON, D. C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-15 (M)
30M REV. 1-68

| 06590 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Item 10, film G401 6/6/68 en | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR A.M. | | | | |
| JACOB | | | | | BLOOM | | | | | Month Day Year
MAY 28 1968 | | | | | 9:30 P.M. | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | |
| MALE | | | | | WHITE | | | | | 4-27-1888 | | | | | 80 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | |
| LITHUANIA | | | | | U.S.A. | | | | | | | | | | BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Balto. County | | | | | 3620 BELLMORE ROAD | | | | | TAILOR | | | | | SHOP | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| MARYLAND | | | | | BALTIMORE | | | | | | | | | | 3620 BELLMORE ROAD | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | |
| UNKNOWN | | | | | UNKNOWN | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | |
| NO | | | | | 214-01-6764 | | | | | MRS. SELMA GOLDSMITH | | | | | 4000 LABYRINTH RD. #15 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarct | | | | | | | | | | | | | | | | | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) ASCVD | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-5-68, 1968, to 4-15-68, 1968, that (I) (we) last saw the deceased alive on 5-22-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Cesar Valle Caverio | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED 5-28-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO | | | | | | | | | | 22e. ADDRESS 8629 LIBERTY ROAD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | | | 5-29-68 | | | | | CHIZUK AMUNO (ARLINGTON) | | | | | BALTIMORE, MARYLAND | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAY 31 1968 | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |

MEDICAL CERTIFICATION

0027

1997

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6098

3901-1185

• 198 •

0409 UNTL 0302

09-01-2011 12:07:11 PM

• • •

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

06591

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06596

| | | | | | | | | |
|--|---------|---|----------|---|--|---|--|---|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR |
| BEATRICE | | | LUDMILLA | BOFFEN | | 5/20/68 19 | | UNK M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year | |
| female | white | 11-7-1917 | | 50 YRS. | | | May 20, 1968 | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Wynnewood | | 1200 Swallow Ct. | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | Baltimore | | Wynnewood | | | | 1200 Swallow Court |
| 14. FATHER'S NAME | | First | Middle | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last |
| Henry | | Sellner | | | | Barbara Faltin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| | | | | Mr. Henry W. Boffen, Sr., 1200 Swallow Ct. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Incised Wound of Neck</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| UNK | | 5/20 19 68 | | cut throat with an electric knife | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town County State | | |
| home | | | | Baltimore, Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL
SIGNATURE | | EXAMINER'S
NAME (Type) | | M.D. | | 22b. DATE SIGNED | | |
| | | Werner U. Spitz, M.D. | | | | 5/21/68 | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | 5-24-1968 | | Meadowridge Cemetery | | Howard County, Maryland | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | MAY 23 1968 | | | | |

10220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|------------------------------|---|---|------------------------------------|--|---|--|--------------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 06592 | | | | | | | | | | |
| 06597 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 20. DATE OF DEATH
Month Day Year | | | 2b. HOUR | |
| MARY | | | E. BOHNE | | | MAY 8 1968 | | | 1:25 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| F | | W | | DEC. 27, 1876 | | | 91 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | Md. |
| - | | U.S.A. | | | | BALTIMORE | | | | |
| 1d. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| COCKEYSVILLE | | | MD. MASONIC HOME | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | - | | BALTO. | | YES | | 124 N. PAYSON STREET | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| CRISTIAN - KAUFMAN | | | JANE AGNES Mc CONVILLE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT | | Address | | | |
| | | | 217-07-0388-D | | MD. MASONIC HOME | | RECORDS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1 Anterolateral heart disease | | | | | | | | | | |
| 174X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 Coronary Pt heart vessel | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Possible Metastasis | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 170X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1965, that (I) (we) lost saw the deceased alive on May 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 1-25 AM May 8, 1968. | | | | | | | | | | |
| 22b. SIGNATURE | | | JAMES H. HAMED MD | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | JAMES H. HAMED MD | | | 22e. ADDRESS | | MASONIC HOME, Cockeysville MD | | |
| | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | | 5-10-68 | | LODON PARK | | BALTIMORE BALTO. MD | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| WM. COOK-BROOKS | | | TOWSON, MD | | | DATE MAY 10 1968 | | Charles Judge | | |

10000

CERTIFICATE OF DEATH

10000



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06592

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06598

| | | | | | | | |
|---|------------------|---|-----------------|--|---|--|---|
| 1. DECEASED-NAME
(Type or Print) | | First
MARY | Middle
ALICE | Last
BOMBERGER | 2a. DATE KNOWN OF
DEATH MATED <input checked="" type="checkbox"/> 5 / 29 19 68 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Dec. 1, 1919 | | 6. AGE (In years
last birthday)
48 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
Month Day Year
May 29, 19 68 | 2d. HOUR
6:45 PM |
| 7a. BIRTHPLACE (State or foreign
country) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital
give street address)
7406 Philadelphia Road | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN
Rosedale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
7406 Philadelphia Road | | 14. FATHER'S NAME
First Middle Last
Mac McGorquodale | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Lilly ALAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
23724 3241 | | 17. INFORMANT
Mary C Jones | | ADDRESS
8061 Roslyn Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE
Charles S. Springate | | EXAMINER'S
NAME (Type)
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED
May 30, 1968 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
June 3, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowdale Memorial Cem. | | 23d. LOCATION (City or Town) (County) (State)
Elkridge Md. | |
| 24. FUNERAL DIRECTOR
Thelma E. Crach | | ADDRESS
1211 Chesapeake Ave. | | 25a. REC'D BY REGISTRAR
DATE JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

06599

06599

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|-------------------|---|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) MARY First A. Middle BORY Last | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 Day 29 Year 1968 | | | 2b. HOUR 1A M | |
| 3. SEX F | 4. RACE W. | 5. DATE OF BIRTH 4/26/1897 | 6. AGE (In years last birthday) 71 YRS. | IF UNDER 1 YEAR
MONTHS 71 DAYS 71 | IF UNDER 24 HRS
HOURS 71 MIN. 71 | 2c. DATE PRONOUNCED DEAD
Month 5 Day 29 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RIDGEWAY MANOR NURSING HOME | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME PETER First NOHA Middle ANNA Last BORASK | | 15. MOTHER'S MAIDEN NAME ANNA First BORASK Middle BORASK Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | |
| 16b. SOCIAL SECURITY NO. 212-34-0409 | | 17. INFORMANT HENRY BORY | | 17. ADDRESS 3101 MARECO AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 431.9 Cardiac Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) 331X
DUE TO, OR AS A CONSEQUENCE OF
(c) 331X
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE WILLIAM GOODMAN | | M.D. WILLIAM GOODMAN | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 31 May 68 | |
| EXAMINER'S NAME (Type) WILLIAM GOODMAN | | ADDRESS (Street, city, town, or county) | | 22c. DATE SIGNED 31 May 68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 6/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM. | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR B. DABROWSKI | | ADDRESS 2818 E. BALTIMORE ST. | | 25a. REC'D BY REGISTRAR JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 06596 MARYLAND STATE DEPARTMENT OF HEALTH 06600 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) HELEN MARIE BOUGHAN | | | 2a. DATE OF DEATH
Month MAY Day 8 Year 1968 | | | 2b. HOUR
M | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
Jan. 21, 1913 | | 6. AGE (In years last birthday)
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Balto | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
BALTO. COUNTY GENERAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
manger | | | 12b. KIND OF BUSINESS OR INDUSTRY
bakery | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Woodlawn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
21207 2004 Alto Vista Ave; | | |
| 14. FATHER'S NAME First Middle Last
Harry Stallings | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Frances S. Hawes | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
212-03-2257 | | 17. INFORMANT
Diane L. Hagner, 2607 Larchmont Drive, Balto | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion
410.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ASHD.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10/58 , 19__, to 5/7/68 , 19__, that (I) (we) last saw the deceased alive on 5/7/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Milton Schlenoff MD | | | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/9/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Milton Schlenoff, M. | | | | 22e. ADDRESS
Windsor Mill Rd. & GwynOak Ave; 21207 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
5/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Pk; 3800 Frederick Rd; Balto; 21229 | | 23d. LOCATION (City or Town) (County) (State)
Balto; 21229 Md. | | | | | |
| 24. FUNERAL DIRECTOR
Loring Byers, 8728 Liberty Rd | | | | 25a. REC'D BY REGISTRAR
21133 | | DATE
MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| 06596 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06601 | | | |
|---|--|--|--|--|--|--|--|----------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| First Samuel Middle Leroy Last Boyd | | | | Month 5 Day 30 Year 68 | | | | 9:15PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | 8/16/96 | | 71 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 315 Ingleside Ave. | | Pipefitter | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Baltimore | | City | | | | 1715 Lydonlea Way | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Samuel Middle L. Last Boyd | | First Mary Middle E. Last Wickham | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) WW I | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| | | 213-16-3656 | | Mary Landon - 1715 Lydonlea Way | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) HEART DISEASE - CORONARY - VASCULAR | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF DISEASE | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) PULMONARY EMBOLISM - EMBOLIC - | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 5/30, 1968, that (I) (we) last saw the deceased alive on 5/30 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | |
| [Signature] | | | | | | | | | | 6/3/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | |
| Dr. H. H. SPAN | | | | | | | | | | 5800 EDWINSON AVE. BALT. 28, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 6/4/68 | | Baltimore National Cem. | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert C. Altenburg Funeral Home, Inc. | | | | | | DATE JUN 6 1968 | | [Signature] | | | |
| 6009 Harford Rd. - Baltimore, Md. 21214 | | | | | | | | | | | |

2232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
MARY | | Middle
H. | | Last
BRADBURN | | 2a. DATE OF DEATH
May Month 4, Day 1968 Year | | 2b. HOUR
12:15 PM |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
December 26, 1898 | | 6. AGE (In years last birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
314 Greenlow Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
314 Greenlow Road | | |
| 14. FATHER'S NAME First Middle Last
William E. Naylor | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Florence Hooker Holmes | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
217-03-8062A | | 17. INFORMANT Address
Mr. Stewart B. Snapp, 6110 Chesworth Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4109</u> <u>Coronary Occlusion, acute</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>Years</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>Nov.</u> , 19 <u>60</u> , to <u>May</u> , 19 <u>68</u> , that (I) we last saw the deceased alive on <u>May 3</u> , 19 <u>68</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. Leo J. Gaver</i> M.D. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 4, 1968 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Leo J. Gaver | | 22e. ADDRESS
1 Mallow Hill Road, Balto., Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-6-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Maryland | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. | | ADDRESS
21229 | | 25a. REC'D MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Judge</i> | | | | |

92320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06593

06603

| | | | | | | | | | | | | |
|--|--|------------------------------|--|---|------------------------------------|---|--|---|---|--|---------|-------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | | |
| WILLIAM R BRATTAIN | | | | | | May 27 1968 | | | 2:00P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| Male | | White | | Aug. 27, 1887 | | | 80 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Indiana | | U.S.A. | | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | | Greater Balto. Medical Cntr | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | Baltimore | | 1928 Baltimore | | | | 1928 Altavue Rd. 21228 | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | |
| Frank Brattain | | | | | | Mary Ann Gallichan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | 305 34 3148 A | | | Hospital Records | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
<u>4129</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4221</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>68</u> , to <u>May 27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | |
| <u>John E. Adams M.D.</u> | | | May 27, 1968 | | | John E. Adams, M.D. | | | 6701 N. Charles Street, Balto. Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) | (State) | |
| Removal | | | May 28 68 | | | | | Lebanon, Indiana | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Wm. Cook-Brooks | | | 12175 Balto. Baltimore | | | MAY 31 1968 | | <u>Charles Judge</u> | | | | |

00380

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06593

06604

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print)
Eva A. Braund | | | 2a. DATE OF DEATH
Month May Day 29 Year 1968 | | | 2b. HOUR
9:30A M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 27, 1886 | | 6. AGE (In years last birthday)
81 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | |
| 10. CITY OR TOWN OF DEATH
Catonsville, Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
211 N. Beechwood Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
211 N. Beechwood Ave | | 14. FATHER'S NAME First Middle Last
Edward A. Sheffler | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sally -- Kirk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
217-40-0011 | | 17. INFORMANT
Mrs. Eugene Higdon- | | Address
115 Melvin Av. Baltimore, Md. 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion, Acute
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Hypertensive Cardio-vascular Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March , 19 55 , to May , 19 68 , that (I) (we) last saw the deceased alive on May 27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Leo J. Gaver</i> DEGREE
Leo J. Gaver, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 31, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Leo J. Gaver, M.D. | | 22e. ADDRESS
1 Mallow Hill Ave., Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 1, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Morningside Cemetery | | 23d. LOCATION (City or Town) (County) (State)
DuBois, Pennsylvania | |
| 24. FUNERAL DIRECTOR
Witzke Fun. Directors, 4101 Edmondson Av. Baltimore, Md. | | 25a. REC'D BY REGISTRAR
JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00330

MINISTRE OF REVENUE

00330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Tapan papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06600 | | | | | | | | | | | | 06605 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|-----------|--|--|--|--|--|------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | | First
ABRAHAM | | | | | | Middle
BRIGHSTEIN | | | | | | Last
BRIGHSTEIN | | | | | | 2a. DATE OF DEATH | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | Month
MAY | | | | | | Day
20 | | | | | | Year
1968 | | | | | | 8A M | | | | | | | | | | | |
| 3. SEX | | | | | | 4. RACE | | | | | | 5. DATE OF BIRTH | | | | | | 6. AGE (In years lost birthday) | | | | | | IF UNDER 1 YEAR | | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | |
| MALE | | | | | | WHITE | | | | | | 9-14-1884 | | | | | | 83 | | | | | | YRS. | | | | | | MONTHS | | | | | | DAYS | | | | | | HOURS | | | | | | MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | |
| ENGLAND | | | | | | U.S.A. | | | | | | | | | | | | BALTIMORE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 28 WARREN PARK DRIVE | | | | | | PROPRIETOR | | | | | | RESTAURANT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | 13b. COUNTY | | | | | | 13c. CITY OR TOWN | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | | | | BALTIMORE | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 28 WARREN PARK DRIVE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | First
HENRY | | | | | | Middle
BRIGHSTEIN | | | | | | Last
BRIGHSTEIN | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | First
PEARL | | | | | | Middle
? | | | | | | Last
? | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NO | | | | | | 216-24-2149 | | | | | | MRS. LILLIAN R. BRIGHSTEIN | | | | | | 28 WARREN PARK DR. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | | | | | | | 10+ years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CHRONIC LEUKEMIA, SEVERE PAGETS DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB. 1957, to 5-20-1967, that (I) (we) last saw the deceased alive on 5-18-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Joseph Deckelbaum M.D. | | | | | | | | | | | | | | | | | | 22c. DATE SIGNED 5-20-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) JOSEPH DECKELBAUM | | | | | | | | | | | | | | | | | | 22e. ADDRESS 3502 W. ROGERS AVENUE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | | 5-21-68 | | | | | | HEBREW FRIENDSHIP | | | | | | BALTIMORE, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | | | | | | | | | | | | | | 25a. RECD BY REGISTRAR DATE MAY 21 1968 | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

13885

WATER AT 12:00

00000

4-14-1904

DATE

PLACE

JOHN MAX WIFE

NAME

RESIDENCE

NAME

4-14-1904

DATE

HYPOCAUSTIC FAILURE

HYPOCAUSTIC FAILURE

CHRONIC KIDNEY, SEVERE PLEURAL DISTASTE

2-15-07

Josephine

2-15-07

JOHN W. WATKINS

JOHN W. WATKINS

DATE

RESIDENCE

JOHN W. WATKINS

06606

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06606

CERTIFICATE OF DEATH

1. NAME OF DECEASED

(Type or Print)

John Tate Brock

2. DATE AND HOUR OF DEATH

May 29, 1968

11:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

5902 Leewood Ave. Baltimore County

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland -Baltimore

C. CITY OR TOWN

Catonsville

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5. SEX

Male

6. RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Jan. 1, 1890

9. AGE (In years
last birthday)

78

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

Clarendon Co. S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Short Brock

14. MOTHER'S MAIDEN NAME

Hester Washington

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

224-18-1782

17. INFORMANT

ADDRESS

Odell Brock-5902 Leewood Avenue

18.

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A)

22. I certify that (I) (this hospital) attended the deceased from May 22, 1968 to May 29, 1968
that (I) (we) last saw the deceased alive on May 29, 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Feodor C. Caguin

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

5-31-68

23C. PHYSICIAN'S
NAME (Type)

Dr. Feodor C. Caguin

DEGREE

23D. ADDRESS

336 E. 25th Street

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/5/68

24C. NAME OF CEMETERY or CREMATORY

Mt. Zero Cemetery

24D. LOCATION

(City, town, or county)

(State)

Silver, South Carolina

VR A1
30M REV

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1968

25B. NAME OF REGISTRAR

Charles Judge

25C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the can papers. Pages 1 and 2 should be filed with the County Department of Health prior to burial.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06607

| | | | | | | | | | | | | |
|--|--|------------------------------|---|---|------------------------------------|--|---|---|---|---|--------|-------------------------------------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
24 HRS. | | | |
| JOHN MICHAEL BROWN | | | | | | MAY 16, 1968 | | | 3 A M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| Male | | White | | October 14, 1945 | | | 22 YRS. | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Carney | | | 2909 Second Ave. | | | Salesman | | | Georgia-Pacific Cor | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Baltimore | | Carney | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2909 Second Ave. | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | |
| Clarence S. Brown | | | | | | Eleanor Brandt | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | 213-46-2857 | | | Mr. Clarence S. Brown | | | Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 581X ACIDOSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) UREMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) CHRONIC NEPHROTIC SYNDROME
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 mo
5 mo
19 YRS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
591X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/7, 1962, to 5/15, 1968, that (I) (we) last
saw the deceased alive on 4/30/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Francis J. Borges MD | | | | | | 22c. DATE SIGNED
3/16/68 | | | 22d. PHYSICIAN'S
NAME (Type) Dr. Francis Borges | | | 22e. ADDRESS
University Hospital |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 5-18-68 | | Dulaney Valley | | | Baltimore Co., Md. | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
6500 York Rd. Baltimore, Md. 21212 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | |

08207

RECORDS OF DEATH

1910-1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A13 (M)
30M REV. 11-66

| 06602 | | | | | | | | | | 06608 | | | | | | | | | | | | | | |
|--|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------------------|--|--|--|--|--|--|--|------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | | | | | |
| Isabel Erdman Bryan | | | | | | | | | | May 10, 1968 6:45 AM | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Female | | | White | | | October 16, 1894 | | | 73 YRS. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Virginia | | | U.S.A. | | | | | | Baltimore Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Towson | | | | | 8 Acorn Circle | | | | | Steno-Clerk | | | | | B&O RR. | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | | | Baltimore | | | | | Towson | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 8 Acorn Circle | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | |
| William H. Bryan | | | | | Barbara E. Erdman | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | |
| No | | | | | 705-12-1257 | | | | | Mrs. Anna E. House | | | | | Same | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
4129
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4200 CEREBROVASCULAR ACCIDENT APPROX 3 YRS AGO | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 9 , 1968, to MAY 10 , 1968, that (I) (we) lost saw the deceased alive on MAY 9 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE T. C. Siwinski | | | | | | | | | | 22c. DATE SIGNED MAY 11, 1968 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Thaddeus Siwinski | | | | | | | | | | 22e. ADDRESS 206 Pennsylvania Ave. Towson | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | 5-13-68 | | | | | Druid Ridge | | | | | Pikesville, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | | | | | | | | | | MAY 13 1968 | | | | | Charles Judge | | | | | | | | | |

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08000

10-10-1955

James H. Jones

10-10-1955

White

White

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 06609 | | | | | | | | | | | |
| 06602 | | | | | | | | | | | |
| 3/15/68 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) BRYANT, BERTHA First Middle Last | | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 3. SEX FEMALE | | | | | | 4. RACE CAUCASIAN | | | 5. DATE OF BIRTH | | |
| 7a. BIRTHPLACE (State or foreign country) W. VA. | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 6. AGE (In years last birthday) 78 YRS. | | |
| 10. CITY OR TOWN OF DEATH DUNDALK | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3209 OLD NT. POINT RD | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | | | | 13b. COUNTY BALTO. | | | 13c. CITY OR TOWN DUNDALK | | |
| 14. FATHER'S NAME First Middle Last JAMES CHESHIRE | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last MARY S. SHAN HOLITZER | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | | | | 16b. SOCIAL SECURITY NO. 232-45-1889 | | | 17. INFORMANT Address MARY B. LUPIN BIN #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
410.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1958 to 5-17, 1968 , that (I) (we) last saw the deceased alive on 5-8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. K. WYMAN M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) WYMAN K. WYMAN M.D. | | | | | | | | 22e. ADDRESS 3209 NORTH POINT RD 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE 5/19/68 | | 23c. NAME OF CEMETERY OR CREMATORY HILLCREST | | 23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD | | | |
| 24. FUNERAL DIRECTOR W. K. WYMAN, BALTO., MD ADDRESS | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

00830

00230

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div>06604</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item #17 Film #G400 5/21/68 ph</div> <div>CERTIFICATE OF DEATH</div> <div>06610</div> | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
EMORY R. BUFFINGTON | | | | | | 2a. DATE OF DEATH Month Day Year
5/17/1968 | | | 2b. HOUR
2 P M | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
11/14/1903 | | | 6. AGE (In years last birthday)
64 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Mt. Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN FARM | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rt #5 Box 138 A. | | | |
| 14. FATHER'S NAME First Middle Last
John E Buffington | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Boone | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
NO | | | | 16b. SOCIAL SECURITY NO.
215-36-7991 | | 17. INFORMANT Richard Buffington Address Westminster, Md. Records, Mt. Wilson State Hospital Rt. #5 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 492X Congestive Heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Co2 Pulmonale
DUE TO, OR AS A CONSEQUENCE OF (c) Pulm. Emphysema, obstructive, severe | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
4 years
8 yrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5271 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/6/1968 , to 5/17/1968 , that (I) (we) lost the deceased on 5/17/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
W Newcomer | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M D. | | | | | | 22e. ADDRESS
Mount Wilson, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
LUTHERAN | | 23d. LOCATION (City or Town) (County) (State)
UNIONTOWN CARROLL MD | | | | | | |
| 24. FUNERAL DIRECTOR
CH Hartzler | | | | | | ADDRESS
NEW WINDSOR MD | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| <div style="display: flex; justify-content: space-between;"> 06606 MARYLAND STATE DEPARTMENT OF HEALTH 06611 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
JOHN SHERMAN BUNNELL | | | | 2a. DATE OF DEATH
Month MAY Day 30 , Year 1968 | | | | 2b. HOUR
12:10 PM | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
8/23/21 | | 6. AGE (In years last birthday)
46 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____
IF UNDER 24 HRS.
HOURS _____ MIN. _____ | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOSPITAL VETERANS ADMINISTRATION | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ILLUSTRATOR-ARTIST | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
509 CATHEDRAL STREET | |
| 14. FATHER'S NAME First Middle Last
LINTHICUM BUNNELL | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ELSIE STEENKEN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES WW II | | 16b. SOCIAL SECURITY NO.
216 14 4162 | | 17. INFORMANT Address
CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG ABSCESS
1570
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) METASTATIC CARCINOMA OF LUNG
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA HEAD OF PANCREAS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
157x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year _____
P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ | | City or Town _____ | | County _____ State _____ | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/10/68 , 19____, to 5/30/68 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/30/68 , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. D. Talbert, M.D. | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/31/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | | 22e. ADDRESS
VA HOSPITAL, FT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
6/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
JENKINS FUNERAL HOME, 4905 YORK RD, BALTO, MD | | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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GRAND NOBLE CITIZEN.

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CALIFORNIA PROMITIV

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|------------------------------|--|--|------------------------------------|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Ellen Chew Burch | | | | | | 5/18/68 | | 12:20P | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| F | | W | | 10/28/1873 | | 94 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Baltimore, Md | | USA | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | Stella Maris Hospice | | | Secretary | | A & P Tea Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | | | | Baltimore | | | | 310 Lyndhurst St | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| John D. Burch | | | Sarah Hammett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | |
| No | | | 216-07-1860-1 | | | Hospice records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4109 | | | | | | | | | Cannon Thrombosis | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | ASCVD. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/10/53, 19__, to 5/18/68, 19__, that (I) (we) last saw the deceased alive on 5/17/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | |
| [Signature] | | | | | | | | 5/18/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| | | | | | | Stella Maris Hospice | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 5/21/68. | | New Cathedral Cemetery | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | DATE MAY 20 1968 | | [Signature] | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06607

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06613

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First <i>ANNA</i> Middle Last <i>BURKE</i> | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>7</i> Year <i>1968</i> | | 2b. HOUR
<i>2:00 P.M.</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>FEB 15, 1902</i> | | 6. AGE (In years lost birthday)
<i>66</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>BALTIMORE</i> | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>3508 OLD MILL RD</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Factory - clothing line</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Washington</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>BALTIMORE</i> | | 13c. CITY OR TOWN
<i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>3508 OLD MILL RD.</i> | | 14. FATHER'S NAME
First <i>JOHN</i> Middle Last <i>BURKE</i> | | 15. MOTHER'S MAIDEN NAME
First <i>SUSAN</i> Middle Last <i>YOCKEL</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>42-03-3121</i> | | 17. INFORMANT
<i>MRS CONNOR</i> | | Address
<i>3508 OLD MILL RD. - BALTO 21207 MD.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>UREMIA</i>
<i>4120</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>HYPERTENSIVE LV DISEASE</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>CORONARY HEART DISEASE</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>ONE WEEK</i>
<i>10 years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>4201</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>OCT 10, 1954</i> to <i>MAY 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>MAY 6, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Edwin L. Pierpont, M.D.</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5/8/69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>EDWIN L. PIERPONT, M.D.</i> | | | | 22e. ADDRESS
<i>8204 LIBERTY RD - BALTO. 21207 MD.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>5-10-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Ellsworth Armacost - 4600 Liberty Hgts</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 8 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | |

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 06603 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06614 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) BURNSTAD ELIZABETH | | | | | | | | | | First Middle Last | | | | | | | | | | 2a. DATE OF DEATH MAY Month 19 Day 1968 Year | | | | | | | | | | 2b. HOUR 4:40am | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX female | | | | | | | | | | 4. RACE white | | | | | | | | | | 5. DATE OF BIRTH 1-28-96 | | | | | | | | | | 6. AGE (In years last birthday) 72 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Balto. MD. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Balto. | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last illness, even if retired.) SPRING GROVE STATE HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during last year, even if retired.) HOUSEWIFE | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY at Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | | | | | | | | 13b. COUNTY BALTIMORE | | | | | | | | | | 13c. CITY OR TOWN Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 573 LUCIA AVENUE | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last UNKNOWN John J. Scullen | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN Margaret C. Clesh | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) UNKNOWN | | | | | | | | | | 16b. SOCIAL SECURITY NO. 217-05-30591 | | | | | | | | | | 17. INFORMANT Address Records- Spring Grove State Hospital | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4120 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF ASACVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Right Hip
DUE TO, OR AS A CONSEQUENCE OF (c) Fracture Right Hip | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/12/67 , 19 67 , to May 19 , 19 68 , that (I) (we) last saw the deceased alive on May 19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Hooton | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 5-19-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Hooton | | | | | | | | | | 22e. ADDRESS Spring Grove State Hospital Baltimore Maryland 21228 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 5/1/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) 5501 Frederick Ave Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR John J. Cowan & Son Inc. | | | | | | | | | | ADDRESS 905 Hollis St. 23 Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAY 21 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--------------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
James | | | Middle
Edward | | | Last
BUSH | | | 2a. DATE OF DEATH
Month 5 Day 16 Year 68 | | | 2b. HOUR
5:20^{AM} | | | |
| 3. SEX
Male | | | 4. RACE
Negro | | | 5. DATE OF BIRTH
2/8/42 | | | 6. AGE (In years
lost birthday)
26 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Rosewood State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Dependent | | | 12b. KIND OF BUSINESS OR
INDUSTRY
none | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
22 North Norris Street | | | | | | |
| 14. FATHER'S NAME
First
Nash | | | Middle
Bush | | | Last
Bush | | | 15. MOTHER'S MAIDEN NAME
First
Mary | | | Middle
Lampkin | | | Last
Lampkin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | | 16b. SOCIAL SECURITY NO.
none | | | 17. INFORMANT
Rosewood Records, Owings Mills, Maryland | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Orthostatic Necrotizing Pneumonia
5/13 X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last: 5/21 X (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 Days | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Severe mental retardation, 12 yrs institutionalization | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/1 , 19 56 , to 5/16 , 19 68 , that <input checked="" type="checkbox"/> (we) last
saw the deceased alive on 5/16 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the
causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard A. Jones | | | DEGREE
M.D. | | | ATTENDING
PHYS. <input type="checkbox"/> | | | MED.
DIRECTOR <input type="checkbox"/> | | | STAFF
PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5/16/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Richard A. Jones, M.D. | | | 22e. ADDRESS
Rosewood St. Hosp., Owings Mills, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
5/21/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
A A County Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Adolphus Halstead | | | ADDRESS
1206 W North Ave | | | REC'D BY REGISTRAR
MAY 17 1968 | | | 25. REGISTRAR'S SIGNATURE
Frank J. Judge | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06610

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06616

| | | | | | |
|--|-------------------------|--|---|--|---|
| 1. DECEASED-NAME
(Type or Print) BONNIE LOUISE CALHOUN (Bonnie Tharp) | | 2a. DATE KNOWN OF DEATH ESTIMATED 5-21-68 | | 2b. HOUR 5:28 M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Jan. 24, 1959 | 6. AGE (In years last birthday) 9 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN 0 |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
School | |
| 10. CITY OR TOWN OF DEATH
Middle River (20) | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baker Ave. Middle River Station Pa. RR | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Baltimore | |
| 13c. CITY OR TOWN
Middle River | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1526 Aldeney Ave. | |
| 14. FATHER'S NAME
William Calhoun | | 15. MOTHER'S MAIDEN NAME
Helen Currey | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) - | |
| 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Arden Tharp | | ADDRESS
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Compound Fractures of
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 805.2
(b) Head, Chest, Legs, Arms etc
DUE TO, OR AS A CONSEQUENCE OF
(c) 7-
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7- | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
802.2 X | | | | | |
| 19a. DATE OF OPERATION
5-21-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Shred by Pa RR TR. #900 (Eng. 4935) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
5-21-68 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Shred by Pa RR TR. #900 (Eng. 4935) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Pa RR TR. Overpass | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Middle River Station Baltn Co Md. | |
| 22a. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
M B Davis | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
5/21/68 | |
| EXAMINER'S NAME (Type)
M. B. Davis, M.D. | | ADDRESS
6800 Mornington Rd Baltimore, Md. 21222 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Memorial Gardens | |
| 23d. LOCATION (City or Town) (County) (State)
Carroll Co. Md. | | 24. FUNERAL DIRECTOR
James E. Bruzdazinski | | 25a. REC'D BY REGISTRAR
MAY 23 1968 | |
| ADDRESS
1407 Eastern Ave. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 06611 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06617 | |
|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) FRANCESCO | | First Middle Last - CAMMARATA | | 2a. DATE OF DEATH
Month 5 Day 6 Year 68 | | 2b. HOUR
9:35 PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7/10/92 | | 6. AGE (In years
last birthday) 75 | |
| 7a. BIRTHPLACE (State or foreign
country) ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) VEH. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) COOK | | 12b. KIND OF BUSINESS OR
INDUSTRY RESTAURANT | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | 13b. CITY BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7213 Old Harford Road | |
| 14. FATHER'S NAME
First Middle Last
Francesco Cammarata | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Guisseppa Cartorna | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown Yes (If yes give war or dates of service) WW I | | 16b. SOCIAL SECURITY NO.
215 03 19 27 | | 17. INFORMANT
Address
CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
436.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)
331X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? NO AUTOPSY | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (at) (in) this hospital attended the deceased from 4/30/68 , 19____, to 5/6/68 , 19____, that (s) (we) lost
saw the deceased alive on 5/8/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (it) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Madhav A. Barhanpurkar | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/6/68 | |
| 22d. PHYSICIAN'S
NAME (Type) MADHAV D. BARHANPURKAR, M.D. | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
5/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR | | ADDRESS
ROBERT C. ALTENBURG FUNERAL HOME
6009 Harford Road, Baltimore, Md. | | 25a. REC'D BY REGISTRAR
MAI 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06612

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06618

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print) TIMOTHY | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year May 4, 1968 | | | 2b. HOUR 9:15 P.M. | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH Nov. 5, 1938 | | | 6. AGE (In years last birthday) 29 YRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Edgemere | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fisherman Inn Box 55A Rt. 10 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nelson Box Co. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Edgemere | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME Harry Cantwell | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME Dorothy Killmeyer | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 212-36-5622 | | | 17. INFORMANT (Mother) Mrs. Dorothy Cantwell, Box 434A Willow Rd. | | | Md. ADDRESS Rt. #10 Edgemere, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shotgun wound of Abdomen
965X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
981X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year 8:15 P.M. May 4, 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shotgun wound of abdomen | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Buliding | | | 21f. LOCATION Street or R.F.D. No. Fisherman Inn Bx55A Rt. 10 | | | City or Town Baltimore State M.D. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum | | | EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 5-5-68 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 5/8/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR MAY 9 1968 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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[Handwritten signature]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MD-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|------------------------------|--|--|------------------------------------|---|--|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | |
| | | | IDA | | | | CAPLAN | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
DAYS | IF UNDER 24 HRS.
HOURS | IF UNDER 24 HRS.
MIN. | 2a. DATE KNOWN OF DEATH |
| FEMALE | WHITE | | | 70 YRS. | | | | | Month MAY Day 18 Year 1968 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| LITHUANIA | | USA | | | | BALTIMORE | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | | 6994 MILBROOK PK. DR. APT. 2C | | | HOUSEWIFE | | AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| MARYLAND | | | BALTIMORE | | | | YES | | 6994 MILBROOK PARK DR. APT. 2C |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| NAPHTOLI | | | PELOVITZ | | | UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| NO | | | NO | | | MISS ESTHER CAPLAN, 6994 MILBROOK PK. APT. 2C | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic C-V. Disease</u> | | | | | | | | | 2 yrs. |
| 4129- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4221 None. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| None. | | | None. | | | None. | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| None | | | None | | | None | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | None. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| D. D. Caples | | | | | | 5/18/68 | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | |
| D. D. CAPLES | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 5-19-68 | | ADATH JESHURON (SODONA) | | BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| SOL LEVINSON & BROS. 6010 REGISTER TOWN, MD | | | | | MAY 21 1968 | | Charles Judge | | |

Case 1:11-cv-00001 Document 1-1 Filed 01/26/12 Page 1 of 1

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22. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|-------------------------|---|--|
| 1. DECEASED-NAME
(Type or print) Isiah | | First Middle Last | | Last Carter | | 2a. DATE OF DEATH
Month May Day 3 Year 1968 | | | 2b. HOUR 6:18 PM | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
May 16, 1907 | | 6. AGE (In years last birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS --- DAYS --- HOURS --- MIN. --- | | IF UNDER 24 HRS.
HOURS --- MIN. --- | |
| 7a. BIRTHPLACE (State or foreign country)
Unknown | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Co. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Reisterstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bent Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Unknown | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1036 Pennsylvania Ave. | | | |
| 14. FATHER'S NAME First Middle Last
Unknown | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Balto. City Welfare Records | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma - Esophagus
150X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
150X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 - 3 , 19 67 , to 5 - 3 , 19 68 , that (I) (we) last saw the deceased alive on 5 - 3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
C.E. McWilliams | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-3-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
C.E. McWilliams | | 22e. ADDRESS
11904 Reisterstown Rd., Reis. Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 7, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
H. J. Eckhardt | | ADDRESS
Owings Mills, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 8 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | |

MEDICAL CERTIFICATION

References

1990-1991

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|-------------------------|---|--|---|---|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) RICHARD Allen | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year May 3, 1968 | | | 2b. HOUR 3:25 P |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
August 1, 1904 | 6. AGE 63 YRS.
(lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month May Day 3 year 19 68 | | | 2d. HOUR 3:25 P |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | |
| 10. CITY OR TOWN OF DEATH
Sparrows Point | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bethlehem Steel Corp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Steam Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
2814 St. Paul Street | | |
| 14. FATHER'S NAME
Edward C. Carter | | | | 15. MOTHER'S MAIDEN NAME
Virginia Satterfield | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO.
215-05-4873 | | 17. INFORMANT ADDRESS
Mrs. Richard Carter, Baltimore, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Traumatic Injuries
921.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
9153 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
P.M. May 3, 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Explosion while at work | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Buliding | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Sparrows Point Baltimore M.D. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Naturol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>
Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE
Ronald N. Kornblum | | | M.D.
Ronald N. Kornblum, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
5-4-68 | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/6/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Greensboro | | | 23d. LOCATION (City or Town) (County) (State)
Greensboro, Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS
MAURICE E. NEUNAM & SON, Easton, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
gcharles Judge | | |

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RECEIVED

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-68 mt. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MAY 18 & 22a film 40 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2a Film GL01 6/27/68 | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|----------------------|--|--|--|--|---|-------------------------|--|--|---|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
EDNA | | | Middle
STREATER | | | Last
CHAMBERS | | | 2a. DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>
May 19 1968 | | | 2b. HOUR
M <input type="checkbox"/> PM | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
March 2, 1939 | | 6. AGE (In years last birthday)
29 YRS. | | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD
Month May Day 19 , Year 1968 | | | 2d. HOUR
4:25 M | | |
| 7a. BIRTHPLACE (State or foreign country)
Wadesboro, N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY BALTIMORE | | | | 13c. CITY OR TOWN
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET AND NUMBER
119 Carroll Street | | | |
| 14. FATHER'S NAME
First James Clayton Middle Streater Last | | | | | | 15. MOTHER'S MAIDEN NAME
First Wilhelminia Middle Sowell Last | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Smith Funeral Home, Wadesboro, N.C. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Status epilepticus
3452
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
3533 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
May 20, 1968 | | | | | |
| EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
May 25, 68 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | | | 23d. LOCATION (City or Town) (County) (State)
Wadesboro N.C. | | | | | | | |
| 24. FUNERAL DIRECTOR
Smith Funeral Home, Wadesboro N.C. | | | | | | 25a. REC'D BY REGISTRAR
MAY 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |

31230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06617

06623

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Thomas Edward CHAMBERS | | | 2a. DATE OF DEATH
Month Day Year
May 2, 1968 | | | 2b. HOUR
8 A.M. | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
August 31, 1905 | | 6. AGE (In years lost birthday)
62 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
2907 Clifton Ave. | | | | | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bertha Henderson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Bertha James 2907 Clifton Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
5932
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Chronic renal insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
603X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/27/ , 19 68 , to 5/2/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/2/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
William
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
May 2, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Gilliani, M.D. | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Reburied | | 23b. DATE
May 6, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park Arbutus Md. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
Zora T. Elickson 429 N. Carroll
ADDRESS | | | | 25a. REC'D BY REGISTRAR
May 6 1968
DATE | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

43883

RECEIVED

1930



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | |
|---|----------------|--|-------------------|--|-------------------------------------|--|---|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M | |
| Frederick | | | | Clagett | 5-14-68 | | 1:19 | |
| 3. SEX | M | 4. RACE | W | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 2-12-70 | | 98 | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | Randall's Town | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore Co. Gen. Hosp | | ELECTRICAL CONTRACTOR | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | |
| Md | | | BALTO. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3000 Woodland Ave. | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| Nathanial | | | | Clagett | Betty Elizabeth | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | 214-34-2523 | | Elsie Clagett Booz - Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Congestion Heart failure
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4200 Possible Carcinoma Lung | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20, 1968, to 5/14, 1968, that (I) (we) last saw the deceased alive on 5/14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | |
| Eunice A | | 5/14/68 | | 22e. ADDRESS
Baltimore Co. Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Cremation | | 5-15-68 | | Loudon Park Cemetery - BALTO MD - | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Ellsworth Armacost | | 4600 Liberty Heights Ave | | MAY 16 1968 | | J. Charles Young | | |

CERTIFICATE OF DEATH

21300

Blank area for text entry, likely containing patient information and medical details.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 06619 MARYLAND STATE DEPARTMENT OF HEALTH 06625 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
NAOMI | | | Middle
P. | | | Last
CLARK | | | 2a. DATE OF DEATH
Month May Day 25 Year 1968 | | | 2b. HOUR
4:25pm | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
8-28-05 | | | 6. AGE (In years last birthday)
62 YRS. | | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
2903 Alden Road 21234 | | | | | |
| 14. FATHER'S NAME First
George | | | Middle
W. | | | Last
Peregoy | | | 15. MOTHER'S MAIDEN NAME First
Emma | | | Middle
Schultz | | | Last
Schultz | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
220-44-9765 | | | 17. INFORMANT
Mrs Naomi Hahn 5 E. Main Blvd Timonium 21083 | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Astrocytoma Grade III, left frontal
1929
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1930 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year _____
P.M. _____ 19 _____ | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work _____ of work _____ | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 68 , to 5-25 , 19 68 , that (I) (we) last saw the deceased alive on 5-25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Jaime Singzon</i> | | | | | | | | | | | | 22c. DATE SIGNED
5-25-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Jaime Singzon, M.D. | | | | | | 22e. ADDRESS
7620 York Road, Baltimore, Md. 21204 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
5-28-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Cemetery Baltimore Co. Md. | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Delair Road 21236 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | | |

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

06620

06626

| | | | | | | | | |
|---|---------|--|--|---|-------------------------------------|---|--|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M | |
| William | | J. | | Collison | May 28, 1968 | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| M | W | | 7/31/1879 | | 88 | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Md. | | U. S. A. | | Baltimore | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Towson | | | Chesapeake Manor N.H. | | | Retired-Architect | | Marine |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | | | Baltimore | | 814 Evesham Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| First Middle Last | | | First Middle Last | | | | | |
| Levin | | | Collison | | Caroline Lantz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | | 216-05-5993 | | Mrs. Evelyn C. Mackenzie (Same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4200 <u>Fractured hip, right</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| May 1968 | | Fractured hip | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 18-1968, to May 28, 1968, that (I) (we) last saw the deceased alive on May 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | |
| Dr. Sylvan D. Goldberg | | | | | | 5/29/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | |
| Dr. Sylvan D. Goldberg | | | | | | Medical Arts Bldg. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 5/31/68 | | Druid Ridge | | Pikesville, Balto. Co. Md. | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md. | | | | MAY 29 1968 | | Charles J. Jones | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

VR A15(4)
30M REV. 1/68

06621

06627

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) H. THEODOSIA | | First Middle Last
CREAGER | | 2a. DATE OF DEATH
Month Day Year
May 31, 1968 | | 2b. HOUR
11:15 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
March 7, 1885. | | 6. AGE (In years last birthday)
83 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chesapeake Manor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1615 Northwick Road | |
| 14. FATHER'S NAME First Middle Last
Claxton Stocksdale | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Helen Stouffer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
220-54-5488 | | 17. INFORMANT Address
Mrs. Louise R. Ely (Same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT
2509
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WEEKS | |
| | | | | | | YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/11 , 19 68 , to 5/31 , 19 68 , that (I) (we) last saw the deceased alive on 5/30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Louis J. Elias, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
6/1/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
LOUIS J. ELIAS, M.D. | | | | 22e. ADDRESS
1701 MERIDENE DR. BALTO. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
6/4/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Blue Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Thurmont, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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CERTIFICATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06628

06628

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) EDITH Mae CROSS | | | 2a. DATE OF DEATH
Month MAY Day 28 Year 1968 | | | 2b. HOUR
12:13 | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JUNE 14, 1886 | | 6. AGE (In years
last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOMEMAKER | | | 12b. KIND OF BUSINESS OR
INDUSTRY
at home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3320 WILLOUGHBY RD. #21234 | |
| 14. FATHER'S NAME First Middle Last
George Philips | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Scrivner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no
(If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
218-07-7718 | | 17. INFORMANT Address
Clara Brown, dght. above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201
(b) thrombosis of right coronary artery disease
(c) Coronary arteriosclerosis | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic gangrene of right lower extremity - amputated. | | | | | | | | | | |
| 19a. DATE OF OPERATION
5/27/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cellulitis right foot
Diabetic gangrene rt. foot | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 1 , 19 68 , to May 28 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence F. Misanik, M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 28, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5/31/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home
3331 Brehms Lane 21213 | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| 1. DECEASED-NAME
(Type or print) | | | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | |
|--|--|--|--|--|---|--|--|---|---|--|
| ERNEST SAMUEL CROSS, Sr. DR. | | | | | | MAY 2 1968 | | | 8:30 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | | White | | April 29, 1879 | | | 89 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| New Hampshire | | U.S.A. | | | | BALTO. | | | Medicine | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | |
| Lutherville | | College Manor Inc. | | | | Physician | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | Balto. | | Baltimore | | YES | | 410 E. Gittings Ave. | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| George Newton Cross | | | Mary Sophia Sawyer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| no | | 213-03-9525 | | Dr. Ernest Cross Jr. | | | 828 Chestnut Ave. 04 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours
unknown | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1963, to May 2, 1968, that (I) (we) last saw the deceased alive on May 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Richard D Hahn</u> MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED May 2-1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) RICHARD D HAHN | | | | | | 22e. ADDRESS 1010 ST PAUL ST BALTO 21202 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Rem. Burial | | 5/8/68 | | Randolph | | Randolph, New Hampshire | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | | 25a. REC'D BY REGISTRAR MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD624

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) First Middle Last
Marie M. Crouse | | | 2a. DATE OF DEATH
Month Day Year
May 12 1968 | | 2b. HOUR
11.50 |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1/15/1898 | |
| 6. AGE (In years lost birthday)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Coatesville, Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore, Co. | | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Towson, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not home, give street address)
Dulaney-Towson Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET AND NUMBER
8413 Saunders Rd. | |
| 13c. CITY OR TOWN
Lutherville | | 13d. STATE
Maryland | | 13e. COUNTY
Balto. Co. | |
| 14. FATHER'S NAME First Middle Last
John L Kilkenny | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Ann Kilkenny | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
215-32-9492 | | 17. INFORMANT Address
Mrs. William B. Phillips (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u>
4409 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
4500 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19, 1966, to MAY 12, 1968, that (I) (we) lost the deceased on MAY 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Joseph D. B. King, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
May 13, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Joseph D. B. King | | 22e. ADDRESS
222 W. Cold Spring Lane | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Sepulchre | |
| 23d. LOCATION (City or Town) (County) (State)
Philadelphia, Pa. | | | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | ADDRESS
4905 York Rd.
Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
MAY 13 1968
DATE | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

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45111

REMARKS OF TANK

1. The tank was filled with water at 10:00 AM. The water level was 10 feet above the bottom of the tank.

2. The water level was 10 feet above the bottom of the tank at 11:00 AM.

3. The water level was 10 feet above the bottom of the tank at 12:00 PM.

4. The water level was 10 feet above the bottom of the tank at 1:00 PM.

5. The water level was 10 feet above the bottom of the tank at 2:00 PM.

6. The water level was 10 feet above the bottom of the tank at 3:00 PM.

7. The water level was 10 feet above the bottom of the tank at 4:00 PM.

8. The water level was 10 feet above the bottom of the tank at 5:00 PM.

9. The water level was 10 feet above the bottom of the tank at 6:00 PM.

10. The water level was 10 feet above the bottom of the tank at 7:00 PM.

11. The water level was 10 feet above the bottom of the tank at 8:00 PM.

12. The water level was 10 feet above the bottom of the tank at 9:00 PM.

13. The water level was 10 feet above the bottom of the tank at 10:00 PM.

14. The water level was 10 feet above the bottom of the tank at 11:00 PM.

15. The water level was 10 feet above the bottom of the tank at 12:00 AM.

SSS V. Gold Mining Corp.

Gold Mining Corp.

Gold Mining Corp.

Gold Mining Corp.

MAY 1931

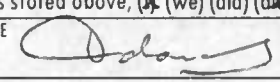
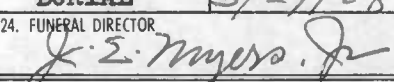
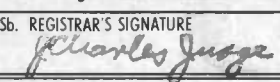
Gold Mining Corp.

Gold Mining Corp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 1-58

| 06625 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06631 | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|---|--|----------|--|---|--|------|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | | | 2b. HOUR | | | | | |
| JOHN | | | | CHRISTIAN | | DAHLGREEN | | MAY 23 1968 | | | | 7:00AM | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| MALE | | WHITE | | 6/19/88 | | | | 79 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | | | | | | | |
| Silver Creek, New York | | U.S.A. | | WIDOWED | | DIVORCED | | BALTIMORE COUNTY, Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | |
| FORT HOWARD | | VET. ADM. HOSPITAL | | | | FOREMAN | | | | GAS & ELECTRIC | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | | | | | |
| MARYLAND | | CARROLL | | WESTMINSTER | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 62 Bond St. | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First | | Middle | | Last | |
| William | | | | Dahlgreen | | | | | | Lena | | | | Ehrke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (no or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | | | | | | |
| Yes | | | | WW I | | 212 05 57 19 | | | | CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. 4221
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS. CYSTITIS CHRONIC | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 4/16/1968, 19__, to 5/23/68, 19__, that (H) (we) last
saw the deceased alive on 5/23/68, 19__, and that in (H) (our) opinion death occurred on the date and hour and from the
causes stated above. (X) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | | | | | | | | 22c. DATE SIGNED
5/23/68 | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) JORGE A. FABARA, M. D. | | | | | | | | | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| BURIAL | | | | 5/27/68 | | SANDY MOUNT CHURCH CEMETERY | | | | FINKSBURG, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR
 | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 27 1968 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | |
| MYERS FUNERAL HOME
WESTMINSTER, MARYLAND | | | | | | | | | | | | | | | | | | | |

5330

150-9 8294

2. 12000 250 17140

4. 3. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 8

REASON: AN IDEALIZED SITUATION: A

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (4)
30M REV. 1/68

| <div>06626</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06632</div> | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | First
STELLA | | | | Middle
J. | | | | Last
DAILEY | | | | 2a. DATE OF DEATH
May 17 Day 1968 Year | | | | 2b. HOUR
6:pm M | | | |
| 3. SEX
FEMALE | | | | 4. RACE
WHITE | | | | 5. DATE OF BIRTH
December 22, 1907 | | | | 6. AGE (In years last birthday)
60 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.A. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
205 Marion Ave., 21234 | | | | | | | |
| 14. FATHER'S NAME First
Macimillian | | | | Middle
Franklin | | | | Last
Catherine | | | | 15. MOTHER'S MAIDEN NAME First
Catherine | | | | Middle
Pozniniak | | | | Last
21236 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown
No | | | | (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
215-09-6147 | | | | 17. INFORMANT
Brother Leo Dailey F.S.C. | | | | Address
205 Marion Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 5900 Bilateral Renal necrotizing papillitis | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Uremic Shock | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Chronic pyelonephritis | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | |
| 6000 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 22, 1968, to May 17, 1968, that (I) (we) last saw the deceased alive on May 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Cillian | | | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5-18-68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M. D. | | | | | | | | | | | | 22e. ADDRESS
7620 York Road, Towson 4, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
5-21-1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road 21236 | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 22 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

08223

08223

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
IN SENATE
JANUARY 10, 1907
REPORT
OF THE
ATTORNEY GENERAL
FOR THE YEAR
1906
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MEDICAL CERTIFICATION

| MAY 15 1968 | | | | | | | | | | |
|---|--|--|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Leroy O. Dawson | | | | | 2a. DATE OF DEATH Month Day Year
May 15, 1968 | | | 2b. HOUR
M | | |
| 3. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
June 6, 1914 | | | 6. AGE (In years lost birthday) YRS.
53 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2 Dunganrie Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Drug Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2 Dunganrie Road | |
| 14. FATHER'S NAME First Middle Last
Luther C. Dawson | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Carolyn Davis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
219-07-4937 | | 17. INFORMANT Address
2 Dunganrie Road Mrs. Eleanor Dawson, Balto., Md. 21228 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
YRS.
YRS. | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 68 , to 5/15 , 19 68 , that (I) (we) last saw the deceased alive on 5/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Edgar Williamson | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/16/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Edgar Williamson | | | | 22e. ADDRESS
PROFESSIONAL ARTS BUILDING 6550 BALTIMORE NATIONAL PIKE | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-18-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
Witzke Funeral Directors, Balto., Md. 21229 | | | | 24b. ADDRESS
4101 Edmondson Avenue | | 25a. REC'D BY REGISTRAR
MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

68339

68339

RECEIVED

TO THE DIRECTOR, BUREAU OF REVENUE
WASHINGTON, D. C.
FROM THE COMMISSIONER, BUREAU OF INTERNAL REVENUE
SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

68339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06623 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06634 | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|--|
| Item 13e, Film # G401 6/5/68 km | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
Addie | | | | | Middle
B. | | | | | Last
Deering | | | | | 20. DATE OF DEATH
Month ^ Day 25 Year 69 | | | | | 2b. HOUR
8 11 M | | | | |
| 3. SEX
F | | | | | 4. RACE
W | | | | | 5. DATE OF BIRTH
June 23, 1880 | | | | | 6. AGE (In years
lost birthday)
87 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 MRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Balto. Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Ridgeway Manor Nursing H | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | | 13b. COUNTY
Balto. | | | | | 13c. CITY OR TOWN
Catonsville | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
2100 Smith Avenue | | | | | | | | | |
| 14. FATHER'S NAME
First
Henry | | | | | Middle
Deering | | | | | Last
Deering | | | | | 15. MOTHER'S MAIDEN NAME First
Permella | | | | | Middle
Deering | | | | | Last
Deering | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
578-34-4472 | | | | | 17. INFORMANT
Homewood Apts., 3009 N. Charles St.
Miss Alice Deering, Balto., Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
4319
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>Sudden</u> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
331X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>66</u> , to <u>24 May</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>24 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>William Goodman, MD</u> | | | | | | | | | | DEGREE
ATTENDING
PHYS. | | | | | <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. | | | | | 22c. DATE SIGNED
<u>25 May 69</u> | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Dr. Wm. Goodman | | | | | | | | | | 22e. ADDRESS
1334 Sulphur Spring Road, Balto. Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | | | 23b. DATE
5-28-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
4101 Edmondson Avenue
Witzke Funeral Directors, Balto., Md. 21229 | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 27 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | |

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
John Deitch | | | 2a. DATE OF DEATH Month Day Year
May 1, 1968 | | | 2b. HOUR p.m.
4:50 | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
May 2, 1890 | | 6. AGE (In years last birthday) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Electroplater | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Bladensburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4208 - 53rd Avenue | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
517-09-8891A | | 17. INFORMANT Address
Records: Spring Grove State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death
410.9 DUE TO, OR AS A CONSEQUENCE OF with Left Bundle Branch Block & Arteriosclerotic Cardiovascular Ht. Dis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1 (b) DUE TO, OR AS A CONSEQUENCE OF previous myocardial infarction (April '67)
(c) Arteriosclerosis, Generalized, Senile
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
2 years
2 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
none | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 29, 1967 to May 1, 1968 , that <input checked="" type="checkbox"/> (we) lost the deceased on May 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Anthony J. Young</i> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 2, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22e. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-6-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
PG County, Maryland | | | |
| 24. FUNERAL DIRECTOR
Wilhelm Funeral Home
4308 Suitland Rd/ SE, Suitland, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAY 6 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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EXHIBIT - B

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06630

06636

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) ISIAH | | First Middle Last | | 2a. DATE OF DEATH
Month MAY Day 25 Year 1968 | | 2b. HOUR
11:15 A.M. | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
7-27-91 | | 6. AGE (In years lost birthday)
76 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
N. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | |
| 10. CITY OR TOWN OF DEATH
Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1034 S. HANOVER ST. | | 14. FATHER'S NAME
First HENRY Middle DEMPSY Last ELLEN | | 15. MOTHER'S MAIDEN NAME
First ELLEN Middle COOPER Last COOPER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address Records, Mount Wilson State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4200 Pulmonary emphysema | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-23 , 19 68 , to 5-25 , 19 68 , that (I) (we) last saw the deceased alive on 5-25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W. Newcomer | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-25-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M.D. | | 22e. ADDRESS
Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | | 23d. LOCATION (City or Town) (County) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR
J. L. Burkett | | ADDRESS
108 W. Montgomery | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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Baltimore County

Mount Vernon

Mount Vernon State College

Mount Vernon State College

Mount Vernon State College

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 418 (M)
30M REV. 1/68

| 06637 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06637 | | | | | |
|--|--|---|---|---|------------------------------------|--|---|---|------|------------------|---|--------|------|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| Mary | | | | John | Jane | Deters | Month | | Day | Year | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | Cau. | | Nov. 16, 1888 | | 79 YRS. | | MONTHS | DAYS | HOURS | MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| Reisterstown | | 116 Sacred Heart Lane | | Housewife | | At Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Md. | | Balto. | | Reisterstown | | | | 116 Sacred Heart Lane | | | | | |
| 14. FATHER'S NAME | | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | First | Middle | Last |
| John Nowell | | | | | | | Mary Ann | | | | Titerington | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| No | | | | None | | Mrs. Margaret Czyzewski, 116 Sacred Heart Lane | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary arteriosclerosis</u> | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> , 19 <u>68</u> , to <u>5/17</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>2/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | Philip Bernstein | | | 22c. DATE SIGNED | | 5/18/68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | Philip Bernstein | | | 22e. ADDRESS | | 112 Chartley Drive, Reisterstown, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | May 21, 1968 | | Cathedral Cemetery | | Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| B. Vernon Simon | | | 4611 Park Heights Ave. Balto. Md. | | | DATE | | MAY 20 1968 | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|-------------------------|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print) Emory Edward Devers | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> May 25 1968 | | | 2b. HOUR 5 A.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Oct. 16, 1890 | 6. AGE (In years last birthday)
77 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month May Day 25 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
Garrett Co., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Academy Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retire- Martins | | 12b. KIND OF BUSINESS OR INDUSTRY
GLENH MARTINS | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN
Owings Mills | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First William Middle Henry Last Devers | | 15. MOTHER'S MAIDEN NAME
First Sarah Middle Ruhama Last Hanlin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) none | | 17. INFORMANT ADDRESS
Mrs. Marg. Devers, Academy Ave., Owings Mills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinomatosis
1538
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(c) 1 1/2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12-18 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1538 | | | | | | | |
| 19a. DATE OF OPERATION
Dec. 1966 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Carcinoma of colon | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH none <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. none P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
none | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
none | | 21f. LOCATION Street or R.F.D. No. City or Town County State
none | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
D. D. Caples | | EXAMINER'S NAME (Type)
D. D. Caples, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-27-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 28, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Stone Chapel Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Pikesville Balto Md. | |
| 24. FUNERAL DIRECTOR
Frank H. Newell, Pikesville, Md. | | | | 25a. REC'D BY REGISTRAR
MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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| NAME | DATE | REMARKS |
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| White | Dec. 10, 1950 | ... |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>06632</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06639</div> | | | | | | | | | | | |
|---|--|--|--|--|---|--|---|---|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) John Preston Dickens | | | | | | 2a. DATE OF DEATH 5 Month 18 Day 68 Year | | | 2b. HOUR 1:55 AM | | |
| 3. SEX M | | 4. RACE Ca | | 5. DATE OF BIRTH 8/12/21 | | | 6. AGE (In years last birthday) 46 YRS. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) West Va | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Driver | | | 12b. KIND OF BUSINESS OR INDUSTRY General Motors | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | 13b. COUNTY Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 825 W 36th St. | | | |
| 14. FATHER'S NAME First Hilery Middle Dickens Last Dickens | | | | 15. MOTHER'S MAIDEN NAME First Sarah Middle Dickens Last Dickens | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | (If yes give war or dates of service) 42-45 234-24-7962 | | 16b. SOCIAL SECURITY NO. 234-24-7962 | | 17. INFORMANT Patients chart | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant pulmonary hemorrhage
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pancoast Tumor, Left upper thoracic
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lung | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163x | | | | | | | | | | | |
| 19a. DATE OF OPERATION 5-9-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED intractable pain Ca | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-8 , 19 68 , to 5-18 , 19 68 , that (I) (we) last saw the deceased alive on 5-18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE ER Soudijn | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5-18-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Edward R Soudijn | | | | | | 22e. ADDRESS GREATER BALTIMORE MED CENTER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Md. | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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| | | | | | | | | |
|---|------------------------------|--|------------------------------------|---|---|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
A M | |
| Baby Boy | | | | Diehl | May 26 1968 | | 11:20 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| Male | Caucasian | May 26, 1968 | | | YRS. | | | 3 |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | USA | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Towson | | Greater Balto. Med. Center | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | |
| | | | | | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle |
| John William Diehl | | | | | Patricia Ann Collison | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| Yes, no, or (unknown) | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Anoxia</u>
<u>551.3</u> DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atelectasis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Congenital Diaphragmatic Hernia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>5604</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 5/26/68 | | Diaphragmatic hernia | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | City or Town | County |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> , 19 <u>68</u> , to <u>5/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | |
| <u>John E. Adams</u> | | 5/28/68 | | | John E. Adams, M.D. | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | |
| | | 6701 N. Charles Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremating | | 5/28/68 | G.B.M.C. | | Towson, Maryland | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| John E. Adams, M.D. | | DATE MAY 31 1968 | | <u>Charles Judge</u> | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|------------------|--|--|--|---|
| 1. DECEASED-NAME
(Type or print) <i>Mary</i> | | First <i>Mary</i> | Middle <i>J.</i> | Last <i>Dietz</i> | 2a. DATE OF DEATH
Month <i>May</i> Day <i>26</i> Year <i>1968</i> | | 2b. HOUR <i>6:10</i> P.M. |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Feb. 8, 1883.</i> | | 6. AGE (In years lost birthday)
<i>85</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Towson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>St. Joseph's Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>4100 Granite Avenue</i> | | 14. FATHER'S NAME First <i>Augusta</i> Middle <i>Ritter</i> Last <i>?</i> | | 15. MOTHER'S MAIDEN NAME First <i>Snyder</i> Middle <i>?</i> Last <i>Snyder</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on or after (If yes give war or dates of service) <i>No</i> | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Mrs. Myrtle Fine</i> | | Address
<i>(Same)</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac malfunction</i>
<i>4100</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Cardio Vascular-renal disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-11-1968</i> , to <i>5-26-1968</i> , that (I) (we) last saw the deceased alive on <i>5-25-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Michael J. Grossfeld M.D.</i> | | DEGREE <i>M.D.</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-27-68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Michael J. Grossfeld M.D.</i> | | 22e. ADDRESS
<i>5101 Stoy Belair Rd Balto. Md.</i> | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>5/29/68.</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore, Md.</i> | | 24. FUNERAL DIRECTOR
<i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> | | 25a. READ BY REGISTRAR
<i>MAY 29 1968</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>James Judge</i> | | | | | | | |

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06636

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06642

| | | | | | | | | | | | | |
|--|------------------|---|---|--|---|--|--|--|---|--|--------|-------|
| 1. DECEASED-NAME
(Type or Print) PHILIP J DIETZ SR | | | First Middle Last | | | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5-15 19 68 Month Day Year | | | | 2b. HOUR 11:15 M | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH AUG. 18, 1923 | 6. AGE (In years last birthday) 44 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month 5 Day 15 Year 68 | | | | 2d. HOUR 11:15 M | | |
| 7a. BIRTHPLACE (State or foreign country) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTO. | | | | | | |
| 10. CITY OR TOWN OF DEATH ESSEX | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1411 HOPEWELL AVE | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHEM. OPER. | | | | 12b. KIND OF BUSINESS OR INDUSTRY GLIDDEN | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN ESSEX | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1411 HOPEWELL AVE | | | |
| 14. FATHER'S NAME ANTHONY J. DIETZ | | | | 15. MOTHER'S MAIDEN NAME PALMER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK | | | 16b. SOCIAL SECURITY NO. 215-18-3384 | | 17. INFORMANT EVELYN DIETZ | | | | ADDRESS ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) H-S-C-V-DISEASE
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 Chronic Asthmatic Bronchitis | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 5/15/68 | | | | | | |
| EXAMINER'S NAME (Type) M.B. Davis M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS 6808 Mount Vernon Ave - Dundalk MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 5/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY WEISBERG | | | 23d. LOCATION (City or Town) PARKTON (County) (State) MD | | | | |
| 24. FUNERAL DIRECTOR J.G. CONNELLY SONS | | | | | ADDRESS 300 MACE | | 25a. REC'D BY REGISTRAR MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE Francis Judge | | | |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-15-64
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|-----|
| 1. DECEASED-NAME (Type or print) <i>Joseph M Dixon</i> | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>19</i> Year <i>68</i> | | | 2b. HOUR
<i>4 A</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
<i>6-2-91</i> | | 6. AGE (In years lost birthday)
<i>76</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Drumpoint MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>BALTO</i> | | | Md. |
| 10. CITY OR TOWN OF DEATH
<i>BALTO</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Greater BALTO Med Center</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>EXCAVATING-EARTH MOVING</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO</i> | | 13c. CITY OR TOWN
<i>BALTO</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>512 E 36th Street</i> | |
| 14. FATHER'S NAME First Middle Last
<i>William Dixon</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Catherine Hardesty</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
<i>Yes V</i> | | 16b. SOCIAL SECURITY NO.
<i>2-28-61-5106A</i> | | 17. INFORMANT
<i>Pt's CHART</i> | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>1621 Resp. ceased</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>CA of the lung (bronchopneumonia)</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>6-7 months</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>1621</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-18</i> , 19 <i>68</i> , to <i>5-19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-19-68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) <i>(did not)</i> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | 22c. DATE SIGNED
<i>5-19-68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Aguistin Collado</i> | | 22e. ADDRESS
<i>Greater BALTO Med. Center</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>May 22, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Kendall Park</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>BALTO. MD</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Dooring Byars, 8728 Liberty Road, Pikesville, MD</i> | | 24a. ADDRESS | | 25a. REC'D BY REGISTRAR
<i>[Signature]</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | DATE
<i>MAY 22 1968</i> | |

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RECEIVED IN DEPT.

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-56

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06633

06644

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
EILEN LUCIAL DIZE | | | 2a. DATE OF DEATH
Month 5 Day 30 Year 68 | | | 2b. HOUR
5:30 A M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
5-13-08 | | 6. AGE (In years lost birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore Co. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Gracie Bette Medical Club | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Club | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
SOMERSET | | 13c. CITY OR TOWN
Crisfield | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
102 South Somerset Street | | | |
| 14. FATHER'S NAME First Middle Last
Edgar - Mallowe | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rosie Ballou Hunsler | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
224-05-3813 | | 17. INFORMANT
Patient Chart Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621 DISSEMINATED CA OF THE LUNGS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that the (this hospital) attended the deceased from 5-10-68, to 5-30-68, that it (we) lost saw the deceased alive on 5:40 AM 5-30-68, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jose M. de Leon, MD | | | | DEGREE
ATTENDING PHYS. | | <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED
5-30-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOSE M. DE LEON, MD. | | | | 22e. ADDRESS
GBMC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
JUNE 2, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
MARINERS CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
CRISFIELD - SOMERSET - MD. | | | | | |
| 24. FUNERAL DIRECTOR
BRADSHAW & SONS - CRISFIELD, MARYLAND | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 544
30M REV. 11-68

| 06633 | | | | | | | | | | 06645 | | | | | | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) TSUNG MER DOW | | | | | 2a. DATE OF DEATH
Month MAY Day 26 Year 1968 | | | | | 2b. HOUR
3:00 P.M. | | | | | | | | | | | | | | |
| 3. SEX
MALE | | | 4. RACE
CHINESE | | | 5. DATE OF BIRTH
4-8-1921 | | | 6. AGE (In years
lost birthday)
47 YRS. | | | IF UNDER 1 YEAR -
MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) CHINA | | | 7b. CITIZEN OF WHAT COUNTRY?
CHINA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore County, Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Mount Wilson | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Mt. Wilson St. Hosp. | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) WRITER | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY SELF-EMPLOYED | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD | | | | | 13b. COUNTY
PRINCE GEORGE | | | | | 13c. CITY OR TOWN
HYATTSVILLE | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
3124 LANDER PLACE | | | | |
| 14. FATHER'S NAME
First PING Middle CHANG Last DOW | | | | | 15. MOTHER'S MAIDEN NAME
First KUO Middle SHIH Last SHIH | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
070-24-5033 | | | | | 17. INFORMANT
Address Records, Mount Wilson State Hosp. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FAIRLY ADVANCED BILATERAL PULMONARY TB.
011.2
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
0021 | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-26-1968 , to 5-26-1968 , that (I) (we) last
saw the deceased alive on 5-26-68 19 10 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
W. Newcomer | | | | | DEGREE ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input checked="" type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
5-26-68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
William Newcomer, M.D. | | | | | 22e. ADDRESS
Mount Wilson, Maryland | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Cremation | | | | | 23b. DATE
5/26/1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State)
BLADENSBURG MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

Washington D.C. W.W. Chambers COI

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 154
30M REV. 1-68

MEDICAL CERTIFICATION

| <div>06640</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06646</div> | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) FRANK J. DOYLE
<i>Frank J. Doyle</i> | | | | Last | | | | 2a. DATE OF DEATH
Month May Day 9 Year 1968 | | | | 2b. HOUR
8:15 A M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
August 1, 1895 | | | | 6. AGE (In years lost birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Timonium, Md. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
117 Gorsuch Rd. Timonium, Md. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Engineer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
C.&P.Tel.Co | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Timonium, Md. | | 13d. INSIDE CITY LIMITS
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
117 Gorsuch Rd. | | | |
| 14. FATHER'S NAME First Middle Last
John T. Doyle | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Katherine Elliott | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) yes (If yes give war or dates of service) WWI | | | | 16b. SOCIAL SECURITY NO.
212-10-0575 | | 17. INFORMANT
Margaret Mary Hennessy | | | | Address
117 Gorsuch Rd. Timonium, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
seconds
24 years | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 5, 1964 , to May 9, 1968 , that (I) (we) last saw the deceased alive on May 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Frederick J. Vollmer MD | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 9, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
FREDERICK J. VOLLMER | | | | 22e. ADDRESS
6100 YORK RD BALTIMORE 21212 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 13, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery Baltimore | | 23d. LOCATION (City or Town) (County) (State)
Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Steading Funeral Estate
736 Edmondson Ave.
Catonsville, Md. 21228 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE
MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE
J. J. Jones | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06642

06647

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Sister Mary Capistean Duman</i> | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>10</i> Year <i>68</i> | | 2b. HOUR <i>5:55</i> AM |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH
<i>2-10-1872</i> | | 6. AGE (In years last birthday) <i>96</i> YRS. | IF UNDER 1 YEAR
MONTHS <i>96</i> DAYS <i>96</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>New York</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Russak</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Glen Arm Rd.</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i> | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | 13b. COUNTY <i>Baltimore</i> | 13c. CITY OR TOWN <i>Russak</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <i>Glen Arm, Rd.</i> | |
| 14. FATHER'S NAME First <i>Stephen</i> Middle <i>Duman</i> Last <i>Duman</i> | 15. MOTHER'S MAIDEN NAME First <i>Hensietta</i> Middle <i>Rolf</i> Last <i>Rolf</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO. <i>218-54-3680</i> | | 17. INFORMANT <i>M. Kathleen</i> | | Address <i>same</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Arteriosclerotic heart disease - chr. bron syndrome</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 week</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4200</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>November 3, 1966</i> , to <i>May 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Henry L. McCorkle MD</i> | | DEGREE <i>MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-25-68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Henry L. McCorkle MD</i> | | 22e. ADDRESS
<i>Phoenix, Maryland 21131</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | 23b. DATE
<i>MAY 13, 1968</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>SISTERS CEMETERY</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>GLEN ARM BALD MD.</i> | |
| 24. FUNERAL DIRECTOR
<i>RAYMOND J. CURRAN</i> | | ADDRESS
<i>817 SCARLETT DR. TOWSON, MD 21204</i> | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 27 1968</i> | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

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OFFICIAL RECORD

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RN-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06642

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06648

| | | | | | | | | | | | |
|---|----------------------|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) BETTY | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year MAY 17 1968 | | 2b. HOUR 5:15 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH JUNE 8, 1923 | | 6. AGE (in years last birthday) 44 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 5 Day 17 Year 1968 5:15 P.M. | |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3608 Fieldstone Road | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Professor | | | 12b. KIND OF BUSINESS OR INDUSTRY Penn State University | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Randallstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 3608 Fieldstone Road | | | |
| 14. FATHER'S NAME Charles J. | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME Laura A. MacEwen | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES World War II | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Charles J. Rose | | ADDRESS 3608 Fieldstone Road Randallstown Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 953 X Suicide by hanging
DUE TO, OR AS A CONSEQUENCE OF
(b) Mental Depression
DUE TO, OR AS A CONSEQUENCE OF
(c) 20 min 2 p.m. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 977 X None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 5 May 17 1968 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hung self on pipe in cellar | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.T.D. No. 3608 Fieldstone Rd. | | City or Town Randallstown | | County Balto. | | State Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE D.D. Caples | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED 5/18/68 | | | |
| EXAMINER'S NAME (Type) D.D. CAPLES | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 20, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Homeless Park | | 23d. LOCATION (City or Town) Woodlawn | | (County) Md. | | (State) | |
| 24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd. Randallstown Md. | | | | 25a. REC'D BY REGISTRAR MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

1. *Prunella vulgaris*
 2. *Prunella vulgaris*

W. D. CAPLE
R. D. Caple

20/9/72

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06642
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06649

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) John Samuel Dyson | | Middle Last | | 2a. DATE OF DEATH
5 Month 30 Day 68 Year | | 2b. HOUR
4:05 M | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
October 21, 1888 | | 6. AGE (In years
lost birthday)
72 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Pines Nursing Home The | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Engineer | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD. | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
408 Winter's Lane | | 14. FATHER'S NAME
First Middle Last
William Dyson | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Catherine Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Ethel Dyson | | Address
408 Winter's Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Repermeation</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Chronic Myocarditis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic Cardiac Vascular Disease</u>
4221 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo.
5 yr.
10 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-7-</u> , 1968, to <u>5-30</u> , 1968, that (I) (we) last saw the deceased alive on <u>5-27-</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Wilmer K. Gallagher M.D.</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-31-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Wilmer K. Gallagher | | | | 22e. ADDRESS
6209 Frederick Avenue, Catonsville, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
6/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, MD. | |
| 24. FUNERAL DIRECTOR
Arlington S. Phillips 1727 N. Monroe Street | | | | 25a. REC'D BY REGISTRAR
JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove forbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and only event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|------------------------------|--|--|---|--|--|--------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | | Middle | | | Last | | |
| Annie Margaret Earp | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| F | | White | | 8/1/18 | | 49 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Lakeland, Fla. | | | USA | | | | | | Balto. | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| Balto. | | | | St. Joseph Hospital | | | | housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | Balto. | | Balto. | | | | Montrose Ave. #12 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Thomas Moore | | | | Lucy Wood | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | |
| No | | | | 159-18-1667 | | H. Shelton Earp | | | | Same as Above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Barbiturate Poison</u>
9500
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
9702 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | | Charles F. O'Donnell, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 5-16-1968 | | Druid Ridge Cem. | | Balto. County Md. | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | | | 25a. REC'D BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. Cook-Brooks Towson, Inc. Towson, Md. | | | | | | MAY 16 1968 | | Charles Judge | | | |

5330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06645

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06651

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>CLARA M. EATON</i> | | | 2a. DATE OF DEATH
Month <i>5</i> - Day <i>19</i> - Year <i>1968</i> | | | 2b. HOUR
<i>11:00 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>JAN 12 - 90</i> | | 6. AGE (In years*
lost birthday) <i>78</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Balto.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Randallstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Balto. County Gen.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Balto</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>32 Summerfield Rd</i> | | | | | | | |
| 14. FATHER'S NAME First Middle Lost | | | 15. MOTHER'S MAIDEN NAME First Middle Lost | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Chart</i> | | | |
| 16c. ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>
<i>2509</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Chronic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Diabetes mellitus</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>260x</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 19, 1968</i> , to <i>May 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Doegracias M. Faustino, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
<i>5/19/68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>DOEGRACIAS V. FAUSTINO</i> | | | | | | 22e. ADDRESS
<i>Baltimore County, San Diego, Randallstown, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>5/28/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>LOU DON PARK</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>BALTO MD</i> | |
| 24. FUNERAL DIRECTOR
<i>J.T. STANBURY</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 22 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. T. Stanbury</i> | |

12930

12930

12930



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-15-64
30M REV. 7-68

Released by Balto. Co. Med. Ex.

| 06646 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06652 | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--------------------------------------|--|---|--|---|--|--------|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | | | |
| HAZEL | | | | C. | | ELLCOTT | | May 16 1968 | | | | M | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | |
| Female | | Cau. | | Mar. 8, 1888 | | | | 80 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Penna. | | U.S.A. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | |
| Baltimore | | 316 Garden Rd. Apt. C. | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | | | | | | | |
| Maryland | | Baltimore | | Baltimore | | | | 316 Garden Rd. Apt. C. | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First | | Middle | | Last | | | |
| ????????? | | | | Conety | | | | | | ???????????????????? | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | | | | | | | | |
| No | | | | 220-44-1708 | | Mr. Charles R. Ellicott, Jr. | | | | 101 Tyrone Rd.
21212 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>4109</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| | | | | | | | | | | | | | | 1 Hr. | | | | | | | |
| | | | | | | | | | | | | | | 10 Yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 6, 1961</u> , to <u>May 16, 1968</u> , that (I) (we) last
saw the deceased alive on <u>Sept. 26, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>A.S. Chalfant</u> | | | | | | | | | | | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYS. DIRECTOR PHYS. | | | | 22c. DATE SIGNED
May 17, 1968 | | | |
| 22d. PHYSICIAN'S
NAME (Type) Dr. A. S. Chalfant | | | | | | | | | | | | | | 22e. ADDRESS
6210 York Road, Baltimore, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| CREMATION | | | | May 20, 1968 | | | | Green Mount | | | | Baltimore, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road
Towson, Md. 21204 | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

| No. | Date | Description | Particulars | Amount | Balance | Total | Remarks |
|-----|---------|-------------|-------------|--------|---------|-------|---------|
| 1 | 1/1/19 | ... | ... | ... | ... | ... | ... |
| 2 | 1/2/19 | ... | ... | ... | ... | ... | ... |
| 3 | 1/3/19 | ... | ... | ... | ... | ... | ... |
| 4 | 1/4/19 | ... | ... | ... | ... | ... | ... |
| 5 | 1/5/19 | ... | ... | ... | ... | ... | ... |
| 6 | 1/6/19 | ... | ... | ... | ... | ... | ... |
| 7 | 1/7/19 | ... | ... | ... | ... | ... | ... |
| 8 | 1/8/19 | ... | ... | ... | ... | ... | ... |
| 9 | 1/9/19 | ... | ... | ... | ... | ... | ... |
| 10 | 1/10/19 | ... | ... | ... | ... | ... | ... |
| 11 | 1/11/19 | ... | ... | ... | ... | ... | ... |
| 12 | 1/12/19 | ... | ... | ... | ... | ... | ... |
| 13 | 1/13/19 | ... | ... | ... | ... | ... | ... |
| 14 | 1/14/19 | ... | ... | ... | ... | ... | ... |
| 15 | 1/15/19 | ... | ... | ... | ... | ... | ... |
| 16 | 1/16/19 | ... | ... | ... | ... | ... | ... |
| 17 | 1/17/19 | ... | ... | ... | ... | ... | ... |
| 18 | 1/18/19 | ... | ... | ... | ... | ... | ... |
| 19 | 1/19/19 | ... | ... | ... | ... | ... | ... |
| 20 | 1/20/19 | ... | ... | ... | ... | ... | ... |
| 21 | 1/21/19 | ... | ... | ... | ... | ... | ... |
| 22 | 1/22/19 | ... | ... | ... | ... | ... | ... |
| 23 | 1/23/19 | ... | ... | ... | ... | ... | ... |
| 24 | 1/24/19 | ... | ... | ... | ... | ... | ... |
| 25 | 1/25/19 | ... | ... | ... | ... | ... | ... |
| 26 | 1/26/19 | ... | ... | ... | ... | ... | ... |
| 27 | 1/27/19 | ... | ... | ... | ... | ... | ... |
| 28 | 1/28/19 | ... | ... | ... | ... | ... | ... |
| 29 | 1/29/19 | ... | ... | ... | ... | ... | ... |
| 30 | 1/30/19 | ... | ... | ... | ... | ... | ... |
| 31 | 1/31/19 | ... | ... | ... | ... | ... | ... |
| 32 | 2/1/19 | ... | ... | ... | ... | ... | ... |
| 33 | 2/2/19 | ... | ... | ... | ... | ... | ... |
| 34 | 2/3/19 | ... | ... | ... | ... | ... | ... |
| 35 | 2/4/19 | ... | ... | ... | ... | ... | ... |
| 36 | 2/5/19 | ... | ... | ... | ... | ... | ... |
| 37 | 2/6/19 | ... | ... | ... | ... | ... | ... |
| 38 | 2/7/19 | ... | ... | ... | ... | ... | ... |
| 39 | 2/8/19 | ... | ... | ... | ... | ... | ... |
| 40 | 2/9/19 | ... | ... | ... | ... | ... | ... |
| 41 | 2/10/19 | ... | ... | ... | ... | ... | ... |
| 42 | 2/11/19 | ... | ... | ... | ... | ... | ... |
| 43 | 2/12/19 | ... | ... | ... | ... | ... | ... |
| 44 | 2/13/19 | ... | ... | ... | ... | ... | ... |
| 45 | 2/14/19 | ... | ... | ... | ... | ... | ... |
| 46 | 2/15/19 | ... | ... | ... | ... | ... | ... |
| 47 | 2/16/19 | ... | ... | ... | ... | ... | ... |
| 48 | 2/17/19 | ... | ... | ... | ... | ... | ... |
| 49 | 2/18/19 | ... | ... | ... | ... | ... | ... |
| 50 | 2/19/19 | ... | ... | ... | ... | ... | ... |
| 51 | 2/20/19 | ... | ... | ... | ... | ... | ... |
| 52 | 2/21/19 | ... | ... | ... | ... | ... | ... |
| 53 | 2/22/19 | ... | ... | ... | ... | ... | ... |
| 54 | 2/23/19 | ... | ... | ... | ... | ... | ... |
| 55 | 2/24/19 | ... | ... | ... | ... | ... | ... |
| 56 | 2/25/19 | ... | ... | ... | ... | ... | ... |
| 57 | 2/26/19 | ... | ... | ... | ... | ... | ... |
| 58 | 2/27/19 | ... | ... | ... | ... | ... | ... |
| 59 | 2/28/19 | ... | ... | ... | ... | ... | ... |
| 60 | 2/29/19 | ... | ... | ... | ... | ... | ... |
| 61 | 2/30/19 | ... | ... | ... | ... | ... | ... |
| 62 | 3/1/19 | ... | ... | ... | ... | ... | ... |
| 63 | 3/2/19 | ... | ... | ... | ... | ... | ... |
| 64 | 3/3/19 | ... | ... | ... | ... | ... | ... |
| 65 | 3/4/19 | ... | ... | ... | ... | ... | ... |
| 66 | 3/5/19 | ... | ... | ... | ... | ... | ... |
| 67 | 3/6/19 | ... | ... | ... | ... | ... | ... |
| 68 | 3/7/19 | ... | ... | ... | ... | ... | ... |
| 69 | 3/8/19 | ... | ... | ... | ... | ... | ... |
| 70 | 3/9/19 | ... | ... | ... | ... | ... | ... |
| 71 | 3/10/19 | ... | ... | ... | ... | ... | ... |
| 72 | 3/11/19 | ... | ... | ... | ... | ... | ... |
| 73 | 3/12/19 | ... | ... | ... | ... | ... | ... |
| 74 | 3/13/19 | ... | ... | ... | ... | ... | ... |
| 75 | 3/14/19 | ... | ... | ... | ... | ... | ... |
| 76 | 3/15/19 | ... | ... | ... | ... | ... | ... |
| 77 | 3/16/19 | ... | ... | ... | ... | ... | ... |
| 78 | 3/17/19 | ... | ... | ... | ... | ... | ... |
| 79 | 3/18/19 | ... | ... | ... | ... | ... | ... |
| 80 | 3/19/19 | ... | ... | ... | ... | ... | ... |
| 81 | 3/20/19 | ... | ... | ... | ... | ... | ... |
| 82 | 3/21/19 | ... | ... | ... | ... | ... | ... |
| 83 | 3/22/19 | ... | ... | ... | ... | ... | ... |
| 84 | 3/23/19 | ... | ... | ... | ... | ... | ... |
| 85 | 3/24/19 | ... | ... | ... | ... | ... | ... |
| 86 | 3/25/19 | ... | ... | ... | ... | ... | ... |
| 87 | 3/26/19 | ... | ... | ... | ... | ... | ... |
| 88 | 3/27/19 | ... | ... | ... | ... | ... | ... |
| 89 | 3/28/19 | ... | ... | ... | ... | ... | ... |
| 90 | 3/29/19 | ... | ... | ... | ... | ... | ... |
| 91 | 3/30/19 | ... | ... | ... | ... | ... | ... |
| 92 | 3/31/19 | ... | ... | ... | ... | ... | ... |
| 93 | 4/1/19 | ... | ... | ... | ... | ... | ... |
| 94 | 4/2/19 | ... | ... | ... | ... | ... | ... |
| 95 | 4/3/19 | ... | ... | ... | ... | ... | ... |
| 96 | 4/4/19 | ... | ... | ... | ... | ... | ... |
| 97 | 4/5/19 | ... | ... | ... | ... | ... | ... |
| 98 | 4/6/19 | ... | ... | ... | ... | ... | ... |
| 99 | 4/7/19 | ... | ... | ... | ... | ... | ... |
| 100 | 4/8/19 | ... | ... | ... | ... | ... | ... |

24 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24 1

06647

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06653

| | | | | | |
|--|--|--|---|--|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
Curtis Le Roy Famous | | | 2a. DATE OF DEATH
Month 5 Day 1 Year 68 4 ¹⁰ A.M. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
3-22-1905 | | 6. AGE (In years lost birthday)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Harford, Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
G.B.M.C. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Agent | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b. COUNTY
Harford Co. | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
338 E. Broadway | |
| 14. FATHER'S NAME First Middle Last
Charles Wesley Famous | 15. MOTHER'S MAIDEN NAME First Middle Last
Anne Heaps Famous | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown? NO | | |
| 16b. SOCIAL SECURITY NO.
212-03-3831 | | 17. INFORMANT (Wife) 838-3599
Mrs. Eva I. Famous 338 East Broadway
Bel Air, Maryland 21014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary heart diseases.
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized arteriosclerosis.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
4-29-68 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Atherosclerosis | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-26-1968, to 5-1-1968, that (I) (we) last saw the deceased alive on 5-1-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. Pirnia M.D. | | DEGREE | ATTENDING PHYS. | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (Type)
A. PIRNIA | | 22e. ADDRESS
G.B.M.C. | | 22c. DATE SIGNED
5-1-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
May 3, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Meth. Ch. Cem. | 23d. LOCATION (City or Town) (County) (State)
Bel Air, Harford Co., Maryland | | |
| 24. FUNERAL DIRECTOR
Joseph William Foster | | ADDRESS
W. Broadway & Williams St.
Bel Air, Maryland 21014 | | 25a. REC'D BY REGISTRAR
MAY 2 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
Joseph Lee Feinour | | | 2a. DATE OF DEATH Month Day Year
May 30, 1968 | | 2b. HOUR a. m.
7:40 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
3-25-1928 | | 6. AGE (In years last birthday)
40 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Balto., Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Balto. Maryland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Humble Oil & Refining Co. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Maryland | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
1761 Weston Ave., 21234 | |
| 14. FATHER'S NAME First Middle Last
Joseph P. Feinor | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Fitzer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217 22 3527 | | 17. INFORMANT Address
Mrs. Catherine Feinour 1761 Weston Ave. 21234 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction.
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 29, 1968 , to May 30, 1968 , that (I) (we) last saw the deceased alive on May 30, 1968 , and that in (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Teodulo Paglinauan, Jr. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
May 30, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Teodulo Paglinauan, Jr., M.D. | | | | 22e. ADDRESS
7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | |
| 24. FUNERAL DIRECTOR
Wm. E. Johnson | | ADDRESS
8521 Loch Raven Blvd. 21204 | | 25a. REC'D BY REGISTRAR
JUN 4 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

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MINUTE OF MEETING

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1954

AT 22 307 Mrs. Catherine Pearson 1701 Madison Ave.

Handwritten signature: Charles H. Johnson

Approved: _____
Date: _____
Secretary: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06649 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06655 | | | | | | | | | |
|--|--|--|--|---|--------|---|--------------------------|---|---|--|----------|--|---------|----------------------|--|-------|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | | |
| MARY F. FERGUSON | | | | | | | 5 | Month | 1 | Day | 68 | Year | 7:35 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| female | | white | | 5/5/27 | | | | 40 YRS. | | MONTHS | | DAYS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Virginia | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | | | Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | 12c. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 3106 Edgewood Rd. | | Assembler | | Bondix Freeze | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 13f. STREET AND NUMBER | | | | | | | |
| Md. | | Baltimore | | Balto | | | | 3106 Edgewood Rd. | | | | | | | | | |
| 14. FATHER'S NAME | | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | First | Middle | Last | | | | |
| Worley G. Frye | | | | | | | Teenie Houshour | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | | | | |
| no | | | | 231-24-1221 | | Charles D. Ferguson | | | | 3106 Edgewood Rd. 21234 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Brain tumor - metastatic adenocarcinoma | | | | | | | | | | | | June 1967 | | | | | |
| 1621 | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) secondary to bronchogenic carcinoma | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) Left lung | | | | | | | | | | | | July 1966 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 1621 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 7-15-67 | | | | Bronchogenic carcinoma | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1966, to May 1, 1968, that (I) (we) last saw the deceased alive on April 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| Charles M. Kerr | | | | | | | | | | | | | | 5-1-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | 22e. ADDRESS | | | |
| Charles M. Kerr | | | | | | | | | | | | | | 6801 Belair Rd 21206 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | | | 5/4/68 | | Dulaney Valley Memorial | | | | Baltimore | | Co. | | Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Lassahn Funeral Home | | | | | | 7401 Belair Rd. | | DATE MAY 6 1968 | | Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | |
|---|--|------------------------------|--|--|--|---|--|--|--|--|--|--|------------|--|
| AUGUSTA G. FINGER | | | | | | | | | | Month Day Year
May 12 1968 | | | 10:50 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| female | | caucasian | | Oct. 16, 1888 | | | | 79 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | |
| Germany | | USA | | | | Baltimore County, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore (suburban) | | | | 7807 Westmoreland Ave. | | | | housewife | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Md. | | | | Baltimore | | Balto. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7807 Westmoreland Ave. | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | |
| Emil | | | | | | | | Klass | | Sophie Meyer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | | |
| No | | | | 213-03-8408 | | Mrs. Bertha Panicho, 7808 Westmoreland Ave. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Leukemia</u> | | | | | | | | | | | | 5 months | | |
| 2070 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 2043 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | |
| | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3.7. 1961, to 5.12. 1968, that (I) (we) last saw the deceased alive on 5.9. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Joseph Skloven</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 5.13.68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Joseph Skloven | | | | | | | | | | 22e. ADDRESS 7122 Harford Rd, Balto. 34, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | | 5/15/68. | | Moreland Memorial | | | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Leonard J. Ruck, Inc. - Balto. 14, Md. | | | | | | | | | | MAY 15 1968 | | <u>Charles Judge</u> | | |

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Approved

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|---|--|---------|---|------------------|----------------------|---|---|--------------------|---|---|------------------|-------------------|--|--|
| Item 23b, File # G401 5/31/68 km | | | | | CERTIFICATE OF DEATH | | | | | 06657 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Henry | | | Fink | | | | | | Month 5 Day 23 Year 68 | | | 3:15 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| male | | white | | 6-13-1884 | | | 83 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | Md. | | |
| Md. | | | U.S.A. | | | | | Balto. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| Baltimore, Md. | | | Chesapeake Manor | | | CVP York, Co | | | LINEMAN | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | Balto. | | | | | | 509 E. Joplin Rd. | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | |
| William | | | Fink | | | | | | Fredricka | | | Schmidt | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| No | | | 212-05-0426 | | | Wm. S. Fink | | | 3006 Moreland Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Arteriosclerotic Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (b) with Cerebrovascular Insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 DUE TO, OR AS A CONSEQUENCE OF (c) Indwelling Catheter & Pyelitis | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Fractured Hip - surgically repaired. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME-FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 58 to May 23 19 68, that (I) (we) last saw the deceased alive on May 22 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | |
| Harik John | | | 5/23/68 | | | F.T. KASIK JR. M.D. | | | 9005 HARFORD RD. | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | 22f. ADDRESS | | | 22g. ADDRESS | | | | | |
| F.T. KASIK JR. M.D. | | | 9005 HARFORD RD. | | | 9005 HARFORD RD. | | | 9005 HARFORD RD. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | 5/27/68 | | | PARKWOOD | | | BALTIMORE Md | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | DATE | | | | | |
| CHAR. F. EVANSON | | | 8802 HARFORD RD | | | MAY 27 1968 | | | Charles Judge | | | | | |

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OFFICE OF THE
DIRECTOR OF THE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEASED-NAME
(Type or print) Marie First E. Middle Foard Last | | | 2a. DATE OF DEATH
May 19, 1968 Month May Day 19 Year | | 2b. HOUR a. 11:35 M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
4-5-37 | | 6. AGE (In years last birthday) 31 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY BALTO. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
4519 Fitch Ave. #21236 | |
| 14. FATHER'S NAME First John Middle Jasper Last | | 15. MOTHER'S MAIDEN NAME First Barbara Middle Schwartz Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
218-32-5729 | | 17. INFORMANT Address
John E. Foard 4519 Fitch Avenue 21236 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Encephalitis.
323X DUE TO, OR AS A CONSEQUENCE OF
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)
(b) Unknown
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
343X | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
5-18-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Encephalitis. | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 11, 1968 , to May 19, 1968 , that XX (we) last saw the deceased alive on May 19, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Eduardo Montelibano DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
May 19, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Eduardo Montelibano, M.D. | | | | 22e. ADDRESS
7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
5-23-1968 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery Baltimore | | 23d. LOCATION (City or Town) (County) (State)
Co. Md. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road 21236 | | 25a. REC'D BY REGISTRAR
MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

08222

RECEIVED

08222

[Faint, mostly illegible text covering the page, possibly a form or document with multiple sections and lines of text.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06652 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06659 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME | | | | | | | | | | 20. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| (Type or print) | | | | | | | | | | First Middle Last | | | | | | | | | | MAY Month 22 Day 1968 Year | | | | | | | | | | 8:05pm | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| FEMALE | | | | | WHITE | | | | | November 3, 1896 | | | | | 71 YRS. | | | | | MONTHS | | | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | U.S.A. | | | | | | | | | | Baltimore | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| Towson | | | | | St. Joseph Hospital | | | | | Housewife | | | | | Housewife | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | Baltimore | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 1857 Cape May Rd., 21221 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | | | | | | |
| John | | | | | Annie | | | | | No. | | | | | 216-24-3811 | | | | | Mr Wilson E. Fowler | | | | | 1311 Regester Avenue | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Liver Cirrhosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 571.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5810 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 29, 1968, to May 22, 1968, that (I) (we) last saw the deceased alive on May 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Camilo Z. Tomboc | | | | | | | | | | | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED May 22, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Camilo Z. Tomboc, M.D. | | | | | | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | | | | | | 5-25-1968 | | | | | | | | | | Moreland Cemetery | | | | | | | | | | Baltimore Co. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Lassahn Funeral Home | | | | | | | | | | 7401 Belair Road 21236 | | | | | | | | | | DATE MAY 27 1968 | | | | | | | | | | J Charles Judge | | | | | | | | | |

63230

LIBRARY OF CONGRESS

63230

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "LIBRARY OF CONGRESS" and "63230" are visible.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06660

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO-RURAL-Parkville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO-RURAL-Parkville</u> | |
| c. LENGTH OF STAY IN 1b <u>19 yrs.</u> | | d. STREET ADDRESS <u>8609 Old Harford Rd 34</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8609 Old Harford Rd 34</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>SOPHIA</u> First <u>M.</u> Middle <u>FRANCIS</u> Last | | 4. DATE OF DEATH <u>MAY 29</u> 19 <u>68</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9 Sept 1891</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-09-8658 B</u> | |
| 17. INFORMANT <u>Howard I Francis - some - husband</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u>
<u>4129</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4221</u>
(b) _____ DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Undiagnosed Gout in bilateral Heels & Arthritis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John C. Hyle</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) <u>7527 Belair Rd 36</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>6/1/68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Leonard J Rueck Inc</u> ADDRESS <u>Baltimore, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>MAY 31 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| <div style="display: flex; justify-content: space-between;"> 06655 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06661 </div> | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> Item 11, Film # G401 6/3/68 km CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Anna Katheryne Francke | | | | | | 2a. DATE OF DEATH
Month 5 Day 22 Year 1968 | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
Cau. | | 5. DATE OF BIRTH
7-30-1877 | | 6. AGE (In years last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Belair Road Housewife | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7407 York Road | | | |
| 14. FATHER'S NAME First Middle Last
Andrew Kummelmann | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Avesser | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
218-46-1676 | | 17. INFORMANT Address
Mrs Margaret Geiger 7407 York Road 21204 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) peripheral atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
yes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4500 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19 68 , to July , 19 68 , that (I) (we) last saw the deceased alive on July 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Milton B. Kirsh, M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Milton B. Kirsh, M.D. | | | | 22e. ADDRESS
4000 W. Northern Parkway - Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-27-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road 21236 | | ADDRESS | | 25a. RECEIVED BY REGISTRAR
MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Judge | | | | | |

12220

RECEIVED

100

100



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) | | | First
Charles | | | Middle
D. | | | Last
Franz Sr. | | | 20. DATE KNOWN OF DEATH
MAY 13 1968 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
7/10/1896 | | 6. AGE (in years last birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 21. DATE PRONOUNCED DEAD
MAY 13 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Buyer Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Rodgers Forge | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES | | 13e. STREET AND NUMBER
231 Rodgers Forge Rd. | | | |
| 14. FATHER'S NAME
Frederick C. Franz | | | | | | 15. MOTHER'S MAIDEN NAME
Nellie Whitaker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16b. SOCIAL SECURITY NO.
216 03 4925 | | 17. INFORMANT
Anne E. Franz | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion - Sudden
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Cardio Renal
64 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) Vascular Disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
64 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
5/14/68 | | | | | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/16/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Gardens | | | | 23d. LOCATION (City or Town) (County) (State)
Texas Balto. M. d. | | | | | |
| 24. FUNERAL DIRECTOR
Mitchell Wiedefeld Home | | | | | | ADDRESS
6500 York Rd. | | 25a. REC'D BY REGISTRAR
MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

622

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1000 York Ave.

358-1700 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>Ruth Fried man</i> | | | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>1968</i> Year | | | 2b. HOUR
<i>8:55</i> M | |
| 3. SEX
<i>female</i> | | 4. RACE
<i>Cauc</i> | | 5. DATE OF BIRTH
<i>[REDACTED]</i> | | 6. AGE (In years lost birthday)
<i>66</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>BALTIMORE, MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>BALTIMORE</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>PIKESVILLE</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>MILFORD MANOR NURSING HOME</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT HOME</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
<i>MARYLAND</i> | | 13b. COUNTY
<i>BALTIMORE</i> | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>6812 TOWNBROOK DR., APT. E</i> | |
| 14. FATHER'S NAME First Middle Last
<i>NATHAN MILLER</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>BESSIE KOENIGSBERG</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>220-46-2793</i> | | 17. INFORMANT Address
<i>MR. JACK FRIEDMAN, 6812 TOWNBROOK DR., APT. E</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Lung</i>
<i>1621</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 yrs.</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>163X</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>May 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>2/2</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Leonard Ketz MD</i> | | 22c. DATE SIGNED
<i>5/2/68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>LEONARD KETZ, MD</i> | | 22e. ADDRESS
<i>11 SCADY AVE BALTO MD 21208</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>5-3-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>ANSHE EMUNAH (AITZ CHAIM)</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>BALTIMORE, MARYLAND</i> | | | |
| 24. FUNERAL DIRECTOR
<i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i> | | | | 25a. REC'D BY REGISTRAR
<i>DATE MAY 7 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | |

5230

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|------------------------------|--|---|--------------------------------|---|--|------------------------|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| James R. Fry | | | | | | Month Day Year
May 1 1968 | | | 6:05 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | White | Aug 17, 1898 | 69 YRS. | | | Month Day Year
May 1 1968 | | | 8 PM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Penna. | | USA | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bowley's Quarters | | | Box 175 Chester Rd. | | | Engineer | | | Aircraft |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | | Baltimore | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box 175 Chester Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
James Fry | | | First Middle Last
Saddie Saricks | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| Yes | | | WVI | | | 174 14 2198 Mildred Patterson Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 Chronic Lung Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | Theodore Patterson, M.D. | | | 105 Main St. Dundalk, Md. 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | 5/4/68 | | | Gardens of Faith Cemetery | | | Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR | | | - ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE |
| Bruzdzinski Funeral Home | | | 1407 Eastern Ave. | | | MAY 3 1968 | | | Charles J. J... |

08284

08284



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Frank Ferdinand GADOW | | | | | | 2a. DATE OF DEATH Month Day Year
May 2, 1968 | | | 2b. HOUR
9:15 AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
July 16, 1911 | | | 6. AGE (In years last birthday)
56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SALESMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL SALES | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2-A Glenmore Ave. | | |
| 14. FATHER'S NAME First Middle Last
FRANK J. Gadow | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
GRACE HAMER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
Yes | | | 16b. SOCIAL SECURITY NO.
212-03-7140 | | 17. INFORMANT Address
MRS. MARION L. Gadow 2-A GLENMORE AVE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
431.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
331X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/30/ , 19 68 , to 5/2/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/2/ , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ramon P. Lopez | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 2, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
6-MAY 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | | 23d. LOCATION (City or Town) (County) (State)
BALTO. Md. | | | | |
| 24. FUNERAL DIRECTOR
J. Walter Conklin | | | | | | ADDRESS
5444 BELAIR RD. | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

2220

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

06660

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06666

| | | | | | | | | | | | | | |
|---|-------------------------|---|--|---|---|---|---|--|---|---|--|------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
FRANK | Middle
ALBERT | Last
GARDNER | 2a. DATE KNOWN OF DEATH
<input type="checkbox"/> ESTI-
<input type="checkbox"/> MATED | | | Month
May | Day
15 | Year
1968 | 2b. HOUR
M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
7-21-15 | 6. AGE (In years last birthday)
52 YRS. | IF UNDER 1 YEAR
MONTHS
0 DAYS
0 | | IF UNDER 24 HRS.
HOURS
0 MIN.
0 | | 2c. DATE PRONOUNCED DEAD
May 15, 1968 | | | 2d. HOUR
8:30 PM | | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Pikesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
8 School House Lane | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Pikesville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
8 School House Lane | | | | |
| 14. FATHER'S NAME
First
Howard | | | Middle
Ernest | | Last
Gardner | | 15. MOTHER'S MAIDEN NAME
First
Mary | | | Middle
Ellen | | Last
Gardner | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
no | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
none | | 17. INFORMANT
Mrs. Helen Hartley | | | ADDRESS
Pikesville 8, Md.
609 Milford Mill Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fatty metamorphosis of liver
571.8
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
5810 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M.
19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | | EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
May 16, 1968 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
May 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Pikesville Baltio. Md. | | 25a. REC'D BY REGISTRAR
May 20 1968 | | | |
| 24. FUNERAL DIRECTOR
Frank H. Newell | | | ADDRESS
Pikesville 8, Md. | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

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06667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06667

| | | | | | | | | |
|--|--|--|--------|---|--|--|--|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month <u>14</u> Day <u>68</u> Year | | 2b. HOUR
<u>1:42</u> M | |
| John | | Harry | | Garmer | | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>2-26-1894</u> | | 6. AGE (In years last birthday)
<u>74</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Baltimore</u> | | Md. |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore 12</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Armacost N.H.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Tax Agent</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Railroad</u> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Md.</u> | | 13b. COUNTY
<u>Balto.</u> | | 13c. CITY OR TOWN
<u>Balto.</u> | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
<u>603 W. 40th St.</u> |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| John | | Henry | | Garmer | Mary | | E. | Lauer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<u>Yes</u> | | (If yes give war or dates of service)
<u>WW1</u> | | 16b. SOCIAL SECURITY NO.
<u>705-05-8415</u> | | 17. INFORMANT
<u>Mrs. Gertrude G. Garmer</u> | | Address
<u>Above</u> |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u>
<u>437.9</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>CHRONIC BRAIN SYNDROME</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CEREBRAL ARTERIOSCLEROSIS.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 DAYS</u>
<u>1 YEAR</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>334X</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> to <u>May 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>MAY 13, 1966</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Arthur Karfgin</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/15/66</u> |
| 22d. PHYSICIAN'S NAME (Type)
<u>Dr. Arthur Karfgin</u> | | | | 22e. ADDRESS
<u>1532 Havenwood Rd., Balto., Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>5-17-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dulaney Valley Mem. Grds.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Timonium, Balto. Co. Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co.</u> | | | | ADDRESS
<u>4905 York Rd., Balto.</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5230

4281-95-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06662 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06668 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| First Gertrude Middle R. M. M. Goble Last | | | | | | | | | | May Month 11 Day 1968. Year | | | | | | | | | | 2 A. M. | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH Nov. 14, 1912. | | | | | 6. AGE (In years last birthday) 55 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Kingsville | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sunshine Ave. | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | | 13b. COUNTY Balto. | | | | | 13c. CITY OR TOWN Kingsville | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER Sunshine Avenue | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Karl Middle A. Last Goble | | | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Huber Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. 217-01-5513 | | | | | 17. INFORMANT Mr. Kenneth Higgs Address (Same) | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lymphoid Leukemia
2049 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
2040 Ch. Cholecytosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-19, 1949, to 5-11, 1968, that (I) (we) last saw the deceased alive on 5-10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Clifford F. Hudson M.D. | | | | | | | | | | | | | | | 22c. DATE SIGNED 5/11/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Clifford F. Hudson M.D. | | | | | | | | | | | | | | | 22e. ADDRESS Fork, Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE 5/14/68. | | | | | 23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State) Belair, Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAY 13 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06662 CERTIFICATE OF DEATH 06669

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 421 Hopkins Rd. | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge
d. STREET ADDRESS 421 Hopkins Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William F. Getchey Jr. | | 4. DATE OF DEATH May 16, 1968 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1901 March 2, 1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auditor | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William F. Getchey Jr. | | 14. MOTHER'S MAIDEN NAME Mary O'Brien | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-03-9002 | |
| 17. INFORMANT Mrs. Ruth S. Getchey | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 DUE TO Coronary Occlusion
(b) Hypertensive - Arteriosclerotic
(c) CardioRenal Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 4201 | | | INTERVAL BETWEEN ONSET AND DEATH Sudden
10 yrs. |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4 October, 1958, to 16 May, 1968 , that (I) we last saw the deceased alive on 16 May 1968 , and that death occurred at M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles F. O'Donnell | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 23b. DATE THEREOF 5/20/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory | | 23d. LOCATION (City, town or county) (State) Balto., Md. | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | 25a. REC'D BY REGISTRAR 6500 York Rd. Balto., Md. 21212 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE Mini 21 1968 | |

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CERTIFICATE OF DEATH

06664

06670

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Concetta</i> | | First Middle Last <i>Glorioso</i> | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>26</i> Year <i>1968</i> | | 2b. HOUR
<i>7:45</i> P.M. | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>August 23, 1897</i> | | 6. AGE (In years last birthday) <i>70</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Italy</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Towson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>St. Joseph Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Seamstress</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>1505 Neighbors Ave.</i> | | 14. FATHER'S NAME
First <i>Salvatore</i> Middle <i>Marsiglia</i> Last <i>Grecu</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Felicia</i> Middle <i>Grecu</i> Last <i>Grecu</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>216-09-9412</i> | | 17. INFORMANT
<i>Mrs. Joseph Mento</i> | | Address
<i>(Same)</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4201</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>May</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>May</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>John G. Orth, M.D.</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5/27/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>John G. Orth M.D.</i> | | 22e. ADDRESS
<i>8019 Philadelphia Rd.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>5/29/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Redeemer Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 27 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07830

07830

1. Name of the person: [illegible]
2. Date of birth: [illegible]
3. Place of birth: [illegible]
4. Sex: [illegible]
5. Marital status: [illegible]
6. Occupation: [illegible]
7. Address: [illegible]
8. City: [illegible]
9. State: [illegible]
10. Zip: [illegible]
11. Signature: [illegible]
12. Date: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|--|--|-----------------------------|--|
| 1. DECEASED-NAME (Type or print) FRANCES C. GLOS | | | | | | 2a. DATE OF DEATH 5 Month 17 Day 1968 Year | | | 2b. HOUR 7²⁵ A M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH Aug. 12, 1884 | | | 6. AGE (In years last birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BLOOMSBURY RETREAT | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Randallstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Box 195 Deer Pk. Rd. | | | |
| 14. FATHER'S NAME First Middle Last Christopher Vogelein | | | | 15. MOTHER'S MAIDEN NAME First Middle Last MARY Catherine Beckmann | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na (or unknown) na | | | 16b. SOCIAL SECURITY NO. 217-54-7647 | | 17. INFORMANT MRS. Charles Glos | | | Address Box 195 Deer Pk. Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL ARTERIO SCLEROSIS
437.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) GENERALIZED ARTERIO SCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 MOS.
3 YEARS | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
334X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 67 , to 5/17 , 19 68 , that (I) (we) last saw the deceased alive on 5/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Paul R. Ziegler MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 5/17/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) PAUL R. ZIEGLER MD. | | | | | | 22e. ADDRESS 200 CHESTNUT HILL DR ELL CITY, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Family Ch. Cem | | 23d. LOCATION (City or Town) (County) (State) HARRISONVILLE, MD. | | | | | | |
| 24. FUNERAL DIRECTOR Wm. J. Tickner & Sons Balto, Md ADDRESS | | | | | | 25a. REC'D BY REGISTRAR MAY 24 1968 DATE | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

17300

RECEIVED

17300



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06666

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06672

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|--|--|---|----------------|--------------------------------|--|---|--|---|----------------------|------------------------|--|--------------|--|----------------------------|--|--|--|----------------|--|--|--|--|--|----------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | Month Day Year | | | 2b. HOUR
11-
M | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PAUL J. GOELLER | | | | | | | | | 5-16-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR
11-
M | | | | | | | | | | | | | | | | | | | | | | | | |
| M | | W | | AUG. 24 1921 | | 46 YRS | | | | | | 5-16-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | |
| MO | | | | USA | | | | | | | | BALTO. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Baltimore DTKS | | | | RTE 15 BOX 312-2nd | | | | SELF EMPLOYED | | | | RESTAURANT | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | |
| MO | | | | BALTO. | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | RTE 15 BOX 312 #W | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GEORGE GOELLER | | | | | | MARY BAIER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| YES | | | | | | WW II | | | | | | 217-16-8453 | | | | | | RITA GOELLER | | | | | | RTE 15 BOX 312 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>STRANGULATION due to HANGING</u>
953X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
974X | | | | | | | | | | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 4-2 5-16 1968 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Heavy Rifle in Capt. Alvin Davis | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
Rt 15 | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Box 312 - Baltimore DTKS Md | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S
NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 5/28/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M.B. DAVIS MD | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS (Street, city, town, or county) 6800 MORNINTON RD | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | MAY 29 1968 | | | | SACRED HEART | | | | BALTO. MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| J.B. CONNELLY SONS | | | | | | | | | | 300 MACE | | | | | | | | | | DATE MAY 31 1968 | | | | | | | | | | f. [Signature] | | | | | | | | | |

88330

88330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR 10-1
304 REV. 1-68

| 06667 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06673 | | | | | |
|---|--|---|--|---|--|---|---|--|--------------------------------|--|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | | 2b. HOUR
1 P. M. | | |
| Charles | | | | Eugene | GOLDSBOROUGH | | May | | 24 | 1968 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 23, 1934 | | | 6. AGE (In years last birthday)
33 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Balto. County Policeman | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7410 Old Harford Rd. | | | | | |
| 14. FATHER'S NAME
Samuel K. Goldsborough | | | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
Hester Lightner | | | | First Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
215-34-6986 | | 17. INFORMANT
Mrs. Ingrid Goldsborough | | | | Address
(Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive subarachnoid hemorrhage</u>
<u>430.9</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of berry aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>330x</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that no (this hospital) attended the deceased from <u>5/24/</u> , 19 <u>68</u> , to <u>5/24/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5/24/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Reynaldo Orjuela-Gomez, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
May 24, 1968 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/27/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

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UNITED STATES OF AMERICA

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RECEIVED

OFFICE

DATE

NO.

TO THE SECRETARY OF THE ARMY

FROM

THE CHIEF OF THE BUREAU OF MILITARY AFFAIRS

SUBJECT

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

RECEIVED [illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) ALAN L. GORDON | | | 2a. DATE OF DEATH
Month 5 Day 23 Year 1968 | | | 2b. HOUR 730 P.M. | | | |
| 3. SEX M. | | 4. RACE W. | | 5. DATE OF BIRTH
Nov. 1, 1898 | | 6. AGE (In years last birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Home Dentist | | 12b. KIND OF BUSINESS OR INDUSTRY Self empl. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Ellistown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 318 Oella Ave. | |
| 14. FATHER'S NAME First Harry Middle Gordon Last Gordon | | | 15. MOTHER'S MAIDEN NAME First Marta Middle Matilda Last Morse | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16b. SOCIAL SECURITY NO. 705-09-8137 | | 17. INFORMANT from record | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Rt
4120
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiac Catheter, Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) A.S.H.D. = Atherosclerotic fibrous | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4200
Intractable Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 24, 1968 to May 23, 1968 , that (I) (we) last saw the deceased alive on 5/23/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Adnan M. Sonmez | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5/23/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Adnan M. Sonmez | | 22e. ADDRESS 1011 Frederick Rd. 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 27, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION (City or Town) Baltimore | | 23e. (County) Maryland (State) | |
| 24. FUNERAL DIRECTOR Sterling Funeral Estate | | ADDRESS 796 Edmondson Ave. Catonsville Md 21228 | | 25a. REC'D BY REGISTRAR MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

47330

22330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1
30M REV 1-68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06669

06675

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) GEORGE WM. GREEN | | First Middle Last | | 2a. DATE OF DEATH
Month May Day 18 Year 1968 | | 2b. HOUR
6:38 M | |
| 3. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
11/16/87 | | 6. AGE (In years last birthday)
80 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Ind. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. | |
| 10. CITY OR TOWN OF DEATH
Barrington, Ind. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Foxleigh Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Vanlt Co. | | 12b. KIND OF BUSINESS OR INDUSTRY
Vanlt Co. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Ind. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Randallstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
John Brun | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Triplett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
213-10-5900 | | 17. INFORMANT
Foxleigh Records - Barrington, Ind. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic C.V. Disease
2509
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs.
5 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X - hypertension | | | | | | | |
| 19a. DATE OF OPERATION
3-24-'68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Benign Prostatic Hypertrophy | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
4:00 P.M. 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
none | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Home | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 68 , to 5/18 , 19 68 , that (I) (we) last saw the deceased alive on 5/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
D.D. CAPLES | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/18/68 | |
| 22d. PHYSICIAN'S NAME (Type)
D.D. CAPLES | | M.D. | | 22e. ADDRESS
Barrington, Ind. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-22-68 | | 23c. NAME OF CEMETERY OR CREMATORY
LAKEVIEW Cemetery | | 23d. LOCATION (City or Town) (County) (State)
SYkesville Md. | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | ADDRESS
Sykesville, Md. | | 25a. REC'D BY REGISTRAR
DATE
MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

4330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|-----------------------------|
| <div style="display: flex; justify-content: space-between;"> 06670 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06676 </div> | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> Item 7b, Film # G400 5/13/68 km CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Roy E. Greer | | | | | | 2a. DATE OF DEATH 5-5-1968 | | | 2b. HOUR 2:00 PM | | |
| 3. SEX Male | | 4. RACE W | | 5. DATE OF BIRTH April 3, 1888 | | | 6. AGE (In years lost birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Canada | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Balto. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7322 Windsor Mill Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 7322 Windsor Mill Road | | |
| 14. FATHER'S NAME First Middle Last David G. Greer | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Margaret Jane Greer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 129-10-4411 | | 17. INFORMANT Mrs. Lloyd Brettschwerdt, 182 Ramblewood Road, Ellitott City, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 492 X Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Emphysema
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 4 , 19 68 , to 5-4 , 19 68 , that (I) (we) last saw the deceased alive on 5-2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 5-6-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Rafael A. Perez Vera | | | | | | 22e. ADDRESS 7306 Liberty Rd., Balto., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 5-8-68 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Balto., Md. | | | |
| 24. FUNERAL DIRECTOR 4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229 | | | | | | 25a. REC'D BY REGISTRAR MAY 7 1968 DATE | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

07280

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RECEIVED BY MAIL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|-------------------|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
John Gregor | | | First Middle Last | | | 2a. DATE OF DEATH
Month <u>5</u> Day <u>2</u> Year <u>68</u> | | 2b. HOUR
<u>7:40AM</u> | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
<u>2/16/1880</u> | | 6. AGE (In years last birthday)
<u>88</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Hungary | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Stella Maris Hospice | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Coal Miner | | 12b. KIND OF BUSINESS OR INDUSTRY
Coal Mines | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2062 E. Belvedere Ave., | |
| 14. FATHER'S NAME
William Gregor | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
Julia Gubesco | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
208-05-5048 A | | 17. INFORMANT
Hospice records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4129 IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Ascites</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) <u>Voluntary</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/54</u> , 19____, to <u>5/2/68</u> , 19____, that (I) (we) lost
saw the deceased alive on <u>5/1/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. _____ | | | | | | | | | |
| 22b. SIGNATURE
Robert J. Mahon | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/2/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert J. Mahon, M.D. | | | | 22e. ADDRESS
204 E. Joppa Rd., Towson | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks | | | | ADDRESS
Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR
DATE MAY 6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

10000

REVENUE OF THE

10000



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06672

06678

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|------------------------------------|--|--|------|--|--|
| 1. DECEASED-NAME
(Type or print) WILLIAM | | | First H. | | | Middle GROSS | | | Last | | | 2a. DATE OF DEATH
Month 5 - Day 6 - Year 68 | | | 2b. HOUR
M | | | | | | | | |
| 3. SEX
MALE | | | 4. RACE
NEGRO | | | 5. DATE OF BIRTH
Oct 17, 1911 | | | 6. AGE (In years last birthday)
56 YRS. | | | IF UNDER 1 YEAR
MONTHS OAYS HOURS MIN. | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign)
A.A. Co., Md | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Balto Co
Catonville, Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
House in Pines N. Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Swift & Co. | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Pasadena | | | 13c. CITY OR TOWN
Pasadena | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Box 390 Woods Road | | | | | | | | | | | |
| 14. FATHER'S NAME
ISIAH | | | First PORTER | | | Middle | | | Last | | | 15. MOTHER'S MAIDEN NAME
MARY | | | First GROSS | | | Middle | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
No. | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
217-07-1416 | | | 17. INFORMANT
Mrs. Alverta Gross | | | | | | | | | Address
Box 390 Woods Rd | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Ca of Prostate
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Anaplastic Bronchogenic Ca
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 mo
1 yr | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1621 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3- , 19 68 , to 5-6- , 19 68 , that (I) (we) last saw the deceased alive on 5-5- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Wilmer K. Gallager, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED
5-7-68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Wilmer K. Gallager | | | | | | | | | | | | | | | 22e. ADDRESS
6209 Frederick Ave. Baltimore, Md. 21228 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
5-9-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Meth. Ch. Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Magothy, Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
MORTON & DYETT F.H. 1701 Laurens Street | | | | | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR
MAY 8 1968 | | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Journal of Management

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|---|---|---|-----------------------------------|--|
| DECEASED-NAME
(Type or print) John | | | First W. Middle HAGGERTY Last | | | 2a. DATE OF DEATH
5 Month 8 Day 68 Year | | | 2b. HOUR
M |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
OCT. 23, 1919 | | | 6. AGE (In years last birthday)
48 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH
CATONSVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
312 MONTROSE AVE | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
312 MONTROSE AVE |
| 14. FATHER'S NAME First Joseph Middle Last HAGGERTY | | | 15. MOTHER'S MAIDEN NAME First Ella Mae Middle Last Knott | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
FAYE LOWE MAGUIRE | | | | Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYO CARDIAC INFARCTION
4109 DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5/8 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Joseph M. Shaw DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
5/8/68 | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN M. SHAW | | | | 22e. ADDRESS
SPAN EMERSON AVE. HAVRE DE LA PRAIRIE, ILL. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY
LORRAINE | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE Md. | | | |
| 24. FUNERAL DIRECTOR
E. S. Mace Nable ADDRESS
301 FREDERICK RD BALTO MD. | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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REMARKS OF DEPT.

THE DEPT. OF THE ARMY, WASHINGTON, D. C.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 06674 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06680 | | | | | |
|---|--|---------|--|------------------|--------|--|------|-----------------------------|--|--|--|---|--|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR | | | |
| KIMBERLY DAWN | | | HAGNER | | | | | | 5-25 1968 | | | 8 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR | |
| Female | | W. | | 9-1-'67 | | YRS. 8 24 | | | | | | May 25 1968 | | 8 AM | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | | |
| Anne Arundel | | | USA | | | | | | Balto. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Swings Mills. | | | Kroenke State Hosp. | | | none | | | none | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | |
| Md. | | | Anne Arundel | | | Burrville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 7818 Brenton Drive | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | |
| John Leroy Wagner | | | Carolyn Diane Wareheim | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. ADDRESS | | | | | | |
| No | | | None | | | Mr. John Wagner (Father) | | | Kroenke Hosp. - Swings Mills, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) asphyxia by aspiration of T. contents | | | | | | | | | | 40 min. | | | | | |
| 742X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) Hydrocephalus | | | | | | | | | | 8 mo. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 752X None. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| None. | | | None | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| None | | | 19 | | | None. | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | None. | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | | | | | |
| D. D. CAPLES | | | M.D. | | | 5-25-'68 | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | Registration, Md. | | | | | | |
| D. D. CAPLES | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | May 27, 1968 | | | Mount Olivet Cemetery | | | Baltimore, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| R. V. Singleton | | | Singleton Funeral Home | | | DATE | | | MAY 29 1968 | | | | | | |
| | | | Glen Burnie, Md. | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| Items#13a,c,e,Film#G400 5/23/68km CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Manie W. Hammack | | | | | | 2a. DATE OF DEATH
5-15-68 Month Day Year | | | 2b. HOUR
7:05 AM | | |
| 3. SEX
Female | | 4. RACE
W | | 5. DATE OF BIRTH
Sept. 28, 1891 | | | 6. AGE (In years lost birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Shady Nook Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Va. | | | 13b. COUNTY
Reedville | | 13c. CITY OR TOWN
Reedville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Route 1 | | |
| 14. FATHER'S NAME First Middle Last
Lanious B. Williams | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Corinna Haynie | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT Address
Mrs. Len D. Lowry, RT, 1 - Reedville, Va. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung -
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral arteriosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
163X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-2- , 19 68 , to 5-15- , 19 68 , that (I) (we) lost the deceased alive on 5-14- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
HARRY L. KNIPP, MD. | | | | | | DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-15-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
HARRY L. KNIPP, MD. | | | | | | 22e. ADDRESS
416 Edmondson Ave., 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-18-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Roseland Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Reedville, Va. | | | | |
| 24. FUNERAL DIRECTOR
4101 Edmondson Avenue
Witzke Funeral Directors, Balto., Md. 21229 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

06676

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06682

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Theodore</i> | | | First Middle Last | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>May</i> Day <i>24</i> Year <i>1968</i> | | | 2b. HOUR <i>1 P</i> M | | | | | | | | | | | | | | |
| 3. SEX <i>Male</i> | | | 4. RACE <i>white</i> | | | 5. DATE OF BIRTH <i>May 3, 1905</i> | | | 6. AGE (In years last birthday) <i>63</i> YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | 2c. DATE PRONOUNCED DEAD <i>May</i> Day <i>24</i> Year <i>1968</i> M | | | 2d. HOUR <i>1 P</i> M | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Baltimore</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>carpenter</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Constr.</i> | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Phoenix</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Manor Road</i> | | | 12c. CITY OR TOWN <i>Phoenix</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER <i>Manor Road</i> | | | 13f. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13g. STREET AND NUMBER <i>Manor Road</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Id.</i> | | | 13b. COUNTY <i>Balto.</i> | | | 13c. CITY OR TOWN <i>Phoenix</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER <i>Manor Road</i> | | | 13f. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13g. STREET AND NUMBER <i>Manor Road</i> | | | | | |
| 14. FATHER'S NAME <i>Louis</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME <i>Margaret Schultz</i> | | | First Middle Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | | 16b. SOCIAL SECURITY NO. <i>216-18-6433</i> | | | 17. INFORMANT <i>Family records</i> | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4109 Coronary Occlusion</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Sudden</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Sudden</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. DATE SIGNED <i>5/24/68</i> | | | 22c. NAME OF CEMETERY OR CREMATORY <i>Jacksonville Reformed Ce.</i> | | | 22d. LOCATION (City or Town) (County) (State) <i>Jacksonville. Md.</i> | | | 22e. REC'D BY REGISTRAR <i>Charles F. O'Donnell</i> | | | 22f. REGISTRAR'S SIGNATURE <i>Charles F. O'Donnell</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b. DATE <i>5/27/68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Jacksonville Reformed Ce.</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Jacksonville. Md.</i> | | | 23e. REC'D BY REGISTRAR <i>John Burns Sons</i> | | | 23f. REGISTRAR'S SIGNATURE <i>Towson</i> | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>John Burns Sons</i> | | | ADDRESS <i>Towson</i> | | | 25a. REC'D BY REGISTRAR <i>John Burns Sons</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Towson</i> | | | DATE <i>MAY 29 1968</i> | | | 25c. REGISTRAR'S SIGNATURE <i>Charles F. O'Donnell</i> | | | | | | | | |

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STATE
DEPT

THE
SECRETARY

TO THE
SECRETARY

FROM THE
SECRETARY

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 524
30M REV. 1-68

MD. DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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06683

| | | | | | | | | | |
|---|--|--|---------------------------|---|--|---|--------------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First
ARTHUR | Middle
CHAMBERS | Last
HARGREAVES | 2a. DATE OF DEATH
Month MAY Day 13 Year 1968 | | 2b. HOUR
1:40 ^A | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
APRIL 18, 1895 | | 6. AGE (In years lost birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country)
MD. (BALTIMORE) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE, Md. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman-retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Gen. Tire Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
TOWSON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
CARDIFF HALL YORK RD. 21204 | |
| 14. FATHER'S NAME First Middle Last
John F. Hargreaves | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret C. ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)
None | | 16b. SOCIAL SECURITY NO.
050-09-6846 | | 17. INFORMANT Address
Family records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
4270
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4341 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 10 , 19 68 , to May 13 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Yusup Oh, M.D. | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
MAY 13, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
YUSUP OH, M.D. | | | | 22e. ADDRESS
7620 YORK ROAD TOWSON, MD. #21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 14, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Maryland | | | |
| 24. FUNERAL DIRECTOR
John Burns' Sons, Towson, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAY 16 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

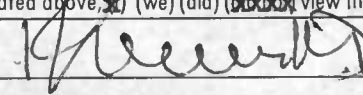
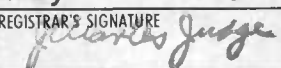
MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

| | | | | | | |
|---|---|---|---|--|--|---|
| 1. DECEASED NAME
(Type or print) STEPHEN | | First | Middle -- | Last HARNEY | 2a. DATE OF DEATH
Month MAY Day 18 Year 1968 | 2b. HOUR
1:00A M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
9/29/07 | | | 6. AGE (In years lost birthday)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERANS ADMIN. HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
PRINTING | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
16 S. CURLEY STREET | | |
| 14. FATHER'S NAME First
JOSEPH | Middle -- | Last HARNEY | 15. MOTHER'S MAIDEN NAME First
Mary Ann Middle
Milosek Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES (If yes give war or dates of service)
WWII | | 16b. SOCIAL SECURITY NO.
216 07 86 61 | | 17. INFORMANT Address
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
4369
DUE TO, OR AS A CONSEQUENCE OF
(b) CEREBROVASCULAR ACCIDENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 337X
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
2 MONTHS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS; URINARY TRACT INFECTION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 9 , 19 68 , to MAY 18 , 19 68 , that (I) (we) last saw the deceased alive on MAY 18 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
 | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5 18 68 | | |
| 22d. PHYSICIAN'S NAME (Type)
RODOLFO G. MIRO, M.D. | | 22e. ADDRESS
VAH, FT. HOWARD, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
May 21, '68 | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | |
| 24. FUNERAL DIRECTOR
JOHN MORAN FUNERAL HOME | | ADDRESS
3000 E. BALTIMORE ST. BALTIMORE, MD. | | 25a. RECD BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4-61)
30M REV. 1-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|------------------------------------|--|---|---|--|--|----------|--|-----|-----------------------------|--|----------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | |
| DOROTHY | | | ISABELLE | | HARRYMAN | | MAY | | Month 20, Day 1968 | | 5:00 PM | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| FEMALE | | | WHITE | | | SEPTEMBER 28, 1907 | | | 60 | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | Md. | | | | |
| MARYLAND | | | U.S.A. | | | | | | BALTIMORE | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| TOWSON | | | ST. JOSEPH HOSPITAL | | | HOMEMAKER | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | |
| MARYLAND | | | Baltimore | | | | | | | | | 3133 NORTHWAY DR. #21234 | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First | | Middle | | Last | |
| | | | | | | | Stegley | | | | | Helen | | | | Chandler | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | |
| | | | | | | 217-03-3709 | | | Pasadena Md. 21122
James Harryman, son, Rt. 1, Box 112D | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage | | | | | | | | | | | | | | | | | |
| 431.9 | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 331X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from MAY 19, 1968, to MAY 20, 1968, that (X) (we) last saw the deceased alive on MAY 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | Ines Cilliani, M.D. | | | | | | 22c. DATE SIGNED | | | May 20, 1968 | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | Ines Cilliani, M.D. | | | | | | 22e. ADDRESS | | | | | | | | |
| | | | | | | | | | 7620 York Rd., Towson, Md. 21204 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | 5/23/68 | | Meadowridge Mem. Park | | | Baltimore, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Schimunek Funeral Home, Inc. | | | | | | | | | DATE MAY 21 1968 | | | Charles Judge | | | | | |
| 3331 Brehms Lane | | | | | | | | | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06686

| | | | | |
|--|--|---|--|---|
| 1. DECEASED-NAME
(Type or Print) <u>Merritt O. Hartson</u> | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>5</u> Day <u>31</u> Year <u>1968</u> | | 2b. HOUR <u>7:30</u> PM |
| 3. SEX <u>M</u> | 4. RACE <u>W</u> | 5. DATE OF BIRTH <u>8-13-23</u> | 6. AGE (In years last birthday) <u>44</u> YRS. | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> |
| 7a. BIRTHPLACE (State or foreign country) <u>Branford Conn.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <u>Baltimore</u> |
| 10. CITY OR TOWN OF DEATH <u>Randallstown, Md.</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Balto. Co. General</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Technician</u> |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <u>Md.</u> | | 13b. COUNTY <u>Balto.</u> | 13c. CITY OR TOWN <u>Randallstown</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME First <u>Merritt</u> Middle <u>O.</u> Last <u>Hartson</u> | | 15. MOTHER'S MAIDEN NAME First <u>Miranda</u> Middle <u>Whittington</u> Last <u> </u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16b. SOCIAL SECURITY NO. <u>215-16-1732</u> | | 17. INFORMANT <u>Mrs. Denis J. Hartson</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u>
<u>4129</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u> </u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Section</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>4221</u> | | | | |
| 19a. DATE OF OPERATION <u> </u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u> </u> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <u> </u> P.M. <u>19</u> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u> </u> | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u> </u> | 21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u> | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion | | | | |
| ACTUAL SIGNATURE <u>James N. Frederick</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <u>5/31/68</u> |
| EXAMINER'S NAME (Type) <u>James N. Frederick</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>1311 Hampden</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>6-6-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lake View</u> | |
| 24. FUNERAL DIRECTOR <u>Lonnie Byers - 8728 Liberty Road</u> | | 25a. REC'D BY REGISTRAR <u>JOHN</u> DATE <u>7 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |
| 23d. LOCATION (City or Town) <u>Carroll</u> | | 23e. LOCATION (County) <u>Md.</u> | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| <div>06687</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06687</div> | | | | | | | | | | |
|---|------------------|--|---|--|---|---|---|--|---|---------------------------|
| 1. DECEASED-NAME (Type or Print) CLIFTON ISIAH HAYNES | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month MAY Day 20 Year 1968 | | | | 2b. HOUR 8:30 P.M. |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 7-26-05 | 6. AGE (In years last birthday) 62 YRS. | IF UNDER 1 YEAR MONTHS 1 DAYS 1 | IF UNDER 24 HRS. HOURS 1 MIN. | 2c. DATE PRONOUNCED DEAD Month MAY Day 20 Year 1968 | | | 2d. HOUR 11:15 P.M. | |
| 7a. BIRTHPLACE (State or foreign country) VA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 523 OVERBROOK RD. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PROPRIETOR - PIXIE SHOP OF COCKEYS | | 12b. KIND OF BUSINESS OR INDUSTRY VILLE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 523 OVER BROOK ROAD | | | |
| 14. FATHER'S NAME First LUCAS Middle HAYNES Last HAYNES | | | | 15. MOTHER'S MAIDEN NAME First RUTH Middle MILBY Last MILBY | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO. 217-14-3899 | | 17. INFORMANT MRS. MARY E. HAYNES | | | ADDRESS (SAME) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA
492X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5271 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE William A. Pillsbury | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED 5/20/68 | | |
| EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, or County) Baltimore, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | | 23d. LOCATION (City or Town) Woodlawn, Balto. Co., | | (County) (State) Md. | |
| 24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Baltimore, 12, Md. | | | | 25a. REC'D BY REGISTRAR MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

43300

UNITED STATES DEPARTMENT OF AGRICULTURE

43300

FOR SALE
BY THE
UNITED STATES
DEPARTMENT OF AGRICULTURE

| Description of Land | | Area | | Value | | Remarks | |
|---------------------|-------|------|-------------|-------|---------|---------|-------|
| 1 | Acres | 2 | Square Feet | 3 | Dollars | 4 | Cents |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 |
| 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 |
| 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 |
| 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 |
| 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 |
| 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 |
| 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 |
| 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>06682</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06688</div> | | | | | | | | | | | |
|---|-----------------------------|--|--|---|---|--|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) George Allen Heisterman | | | | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5-28 68 105 M | | 2b. HOUR | | 2c. DATE PRONOUNCED DEAD 5-28 68 105 M | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
6-14-06 | 6. AGE (In years last birthday)
61 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | 2e. DATE PRONOUNCED DEAD | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH
Middle River | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
10 E. Hickham Rd. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Middle River | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10 E. Hickham Rd. | | |
| 14. FATHER'S NAME
Charles W. Heisterman | | | | 15. MOTHER'S MAIDEN NAME
Luella R. Hutchinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Miss Emma Hutchinson | | | ADDRESS
Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OH-S-C-V- Disease
1538
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ca. of Large Bowel
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 Mos | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1538 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.E.D. No. | | | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dr. Melvin Davis M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
5/29/68 | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ADDRESS (Street, city, town, or county) | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
6/1/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Pk. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | | 23e. REC'D BY REGISTRAR
MAY 31 1968 | | 23f. REGISTRAR'S SIGNATURE
J. Charles Judge | |

1888

1888

James Allen Hamilton

Commissioner of the

Land

State of

Theresa M. Hamilton

James Allen Hamilton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|---|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>George</i> | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>31</i> Year <i>68</i> | | | 2b. HOUR
M |
| 3. SEX
<i>male</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>Dec-2 1889</i> | | | 6. AGE (In years
last birthday)
<i>78</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country) <i>IOWA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>BALTIMORE</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Colemanville Md</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Summit Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>MANAGER</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>CLOTHING</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
<i>5104 PLAINFIELD RD</i> | | 13b. COUNTY
<i>BALTO</i> | | 13c. CITY OR TOWN
<i>MD</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>5104 PLAINFIELD RD</i> | | | |
| 14. FATHER'S NAME
First Middle Last
<i>HELLER - GEORGE HELLER</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>ELIZABETH DELL</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>26-54-7111</i> | | 17. INFORMANT
Address
<i>MRS ROBT HARRISON 1316 MIDDLEFORD RD 21228</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Hydro-nephrosis with chronic outcome</i>
<i>599.0</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>URINARY TRACT INFECTION.</i> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>609X</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Covering for T. Roach, M.D.</i>
<i>E. Kasaitis, M.D.</i> | | DEGREE | | ATTENDING
PHYS. | | MED.
DIRECTOR <input type="checkbox"/> | | STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5/31/68</i> | |
| 22d. PHYSICIAN'S
NAME (Type) <i>E. KASAITIS, M.D.</i> | | 22e. ADDRESS <i>1801 FREDERICK RD
BALTIMORE, MD 21228</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<i>6/3/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>MORRIS MEMO PARK PARKVILLE</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>MD</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>ULLRICH FUNERAL HOME - 4210 BELAIR RD</i> | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>JUN 3 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06684

06690

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) HENRIETTA | | | First HELLER | | | Middle | | | Last | | | 2a. DATE OF DEATH
May 14, 1968 | | | 2b. HOUR
M | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
November 5, 1889 | | | 6. AGE (In years last birthday)
78 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Canada | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
English Consul | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2736 Alderwood Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN English Consul | | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
2736 Alderwood Road | | | | | |
| 14. FATHER'S NAME First August Middle Tefke Last | | | 15. MOTHER'S MAIDEN NAME First Unknown Middle Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address St. Rev. Alwin C.J. Schneider, 3143 Strickland | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular Disease
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-3 yr
6-8 yr | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4221 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14/68 , to 5/14 , 19 68 , that (I) (we) last saw the deceased alive on 5/14/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Chas. L. Ball Jr. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED
5/14/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Charles L. Ball, Jr. | | | | | | 22e. ADDRESS
203 W. Maple Road, Linthicum, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)
BURIAL | | | 23b. DATE
5-17-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Howard County, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | 25a. REC'D BY REGISTRAR
MAY 17 1968 | | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | | | | | | | | |

MEDICAL CERTIFICATION

4223

23230

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAY 5 1968 | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|-----------------------------------|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last
Eleanor Kreinheder Hemmeter | | | | | | 2a. DATE OF DEATH Month Day Year
May 5, 1968 | | | 2b. HOUR
5:30 PM | | |
| 3. SEX
Female | | 4. RACE
W | | 5. DATE OF BIRTH
March 3, 1881 | | | 6. AGE (In years last birthday)
87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
N. J. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore City Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chapel Hill N. H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
--- | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
Jessup | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First Middle Last
Louis Reinsch | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Eleanor Koch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
220-22-9867 | | 17. INFORMANT
Mrs. William H. Engelhaupt, Jessup, Md. | | | | Address Box 380 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY INFARCTION
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) A.S. C.V.D.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
10 YRS. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 68 , to 5-5 , 19 68 , that (I) (we) last saw the deceased alive on 5-5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. V. Honch, Jr., M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
5-5-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
R. V. Honch, Jr., M. D. | | 22e. ADDRESS
Sykesville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-8-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR
4101 Edmondson Avenue
Witzke Funeral Directors, Balto., Md. 21229 | | | | | | 25a. REC'D BY REGISTRAR
MAY 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|----------------------|--|---|--|---|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>Kermit Laban Hershey Jr.</i> | | | 2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <i>May 20, 1968</i> | | | 2b. HOUR <i>2 A M</i> | | | |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>May 20, 1944</i> | 6. AGE (In years last birthday) <i>24</i> YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month <i>May</i> Day <i>20,</i> Year <i>1968</i> | | 2d. HOUR <i>5A M</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Gettysburg Pa.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Reisterstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rt. 140 Westminster Road</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Cambridge Rubber Co.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Carroll</i> | | 13c. CITY OR TOWN <i>Westminster</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>26 Webster Street</i> | |
| 14. FATHER'S NAME First <i>Kermit</i> Middle <i>L.</i> Last <i>Hershey Sr.</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Brown</i> Last <i>Brown</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> | | 16b. SOCIAL SECURITY NO. <i>63-66 218-40-8845</i> | | 17. INFORMANT <i>Mr. Kermit L. Hershey Sr.</i> | | | ADDRESS <i>Westminster, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Drowning(auto ran thru guard rail)</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>8169</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>8234</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>2 5-20-68</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Ran thru guardrail & submerged in 7 ft. water.</i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Rt. 140-Westminster Rd.</i> | | 21f. LOCATION Street or R.F.D. No. <i>Reisterstown</i> | | City or Town <i>Balto.</i> | | County <i>Md.</i> | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>D. D. Caples</i> | | EXAMINER'S NAME (Type) <i>D. D. Caples, M. D.</i> | | 6 Hanover Rd. <i>Reisterstown, Md.</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>5-20-68</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>May 22, 68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Memorial</i> | | 23d. LOCATION (City or Town) <i>Finksburg, Md.</i> | | (County) (State) | |
| 24. FUNERAL DIRECTOR <i>J. E. Myers Jr. Westminster, Md.</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR <i>MAY 24 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | |

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FOR STATE
RECORD ONLY

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U. S. Census, W. P.

U. S. Census, W. P.

U. S. Census, W. P.

U. S. Census, W. P.

U. S. Census, W. P.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) Charles Ralph Chenworth Hess | | First Middle Last | | 2a. DATE OF DEATH
Month May Day 2 Year 1968 | | 2b. HOUR 8:00 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 12, 1906 | | 6. AGE (In years last birthday) 61 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Long Green | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Manor Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
School bus driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Transportation | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Long Green | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Charles Ball Hess | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
Emma Elizabeth Chenworth | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
218-32-4787 | | 17. INFORMANT
Alice S. Hess | | Address Manor Road Long Green, Md. 21092 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF COLON (LT) & SE.
1532
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MOS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1532 | | | | | | | |
| 19a. DATE OF OPERATION
1/17/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CA COLON | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month 1 Day 17 Year 1968
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-17-68 , 19 68 , to 5-2-68 , 19 68 , that (I) (we) last saw the deceased alive on 5-2-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
CLIFFORD F. HUDSON | | | | | | 22c. DATE SIGNED
5/3/68 | |
| 22d. PHYSICIAN'S NAME (Type)
CLIFFORD F. HUDSON | | | | | | 22e. ADDRESS
FORK MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/5/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Jarrettsville | | 23d. LOCATION (City or Town) (County) (State)
Jarrettsville, Harford, Md. | |
| 24. FUNERAL DIRECTOR
Charles E. Kurtz Jarrettsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

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1. The first part of the report is a general statement of the work done during the year. It includes a summary of the results of the various projects and a statement of the progress made in the various fields of research.

2. The second part of the report is a detailed account of the work done in the various fields of research. It includes a description of the methods used, a statement of the results obtained, and a discussion of the significance of the results.

3. The third part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

4. The fourth part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

5. The fifth part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

6. The sixth part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

7. The seventh part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

8. The eighth part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

9. The ninth part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

10. The tenth part of the report is a summary of the work done in the various fields of research. It includes a statement of the progress made in the various fields of research and a statement of the results obtained.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 223. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

06688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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| | | | | | | | | | |
|---|---------|---|---|---|--|---|------------------------|----------------------------|---|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR |
| BERNARD | | | CLAUDE | HILLSINGER | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input type="checkbox"/> 5 28 19 68 5:00 | | | 2b. HOUR | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR |
| Male | White | June 14, 1912 | 55 YRS. | | | May 28 19 68 5:00 | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| Pa. | | U. S. A. | | | | Baltimore | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| Woodlawn | | | Dogwood Rd. & Rolling Rd. | | | Brick Mason | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | |
| MD. | | | BALTO. | | Balto. | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 1215 Stella Dr. |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Claude V. Hillsinger | | | | | | Nellie E. Hillsinger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS |
| Yes | | | WW 2 | | 579-09-6490 | | | | 1215 Stella Drive
Mrs. Charolotte Hillsinger, Balto., Md. 21207 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease
4120
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
443X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson, M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) 22b. DATE SIGNED May 29, 1968 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6-1-68 | | Lorraine Park Cemetery | | Balto., Md. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Witzke Funeral Directors, Balto., Md. 21229 | | | | | | DATE MAY 31 1968 | | Charles J. [Signature] | |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) FELIX | | First F | | Middle | | Last HOERNIG | | 2a. DATE OF DEATH
Month May Day 18 Year 1968 | | 2b. HOUR PM MIN 11:45 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
January 21, 1901 | | 6. AGE (In years lost birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Western Elec. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
 | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
21234 7916 Westmoreland Ave. | | | |
| 14. FATHER'S NAME First Henry Middle G Last Hoernig | | 15. MOTHER'S MAIDEN NAME First Caroline Middle Kunz Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
215-03-9654 | | 17. INFORMANT
KATHERINE R. HOERNIG | | Address Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atrial Fibrillation
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Pulmo | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4200 Pulmonary Embolism | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 11, 1968 , to May 18, 1968 , that (I) (we) last saw the deceased alive on May 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Eduardo Montelibano, M.D. | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 18, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Eduardo Montelibano, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
May 22, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
CARLEWOOD | | 23d. LOCATION (City or Town) (County) (State)
BALTO MD | | | | | |
| 24. FUNERAL DIRECTOR
Chas. P. Evans + Son | | ADDRESS
8802 Harford Rd | | 25a. RECEIVED BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | |
|---|--|---|--------|--|-------------------|---|----------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| Joseph J. HOLTHAUS | | | | | Month | Day | Year | 12:50 P.M. |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 18, 1911 | | 6. AGE (In years last birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | IF UNDER 24 HRS.
HOURS MIN. |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Supervisor-Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
Martin Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)
STATE
Maryland | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
118 Leslie Ave. |
| 14. FATHER'S NAME
First Middle Last
Jacob Holthaus | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Barbara Messner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-01-6086 | | 17. INFORMANT
Address 21206
Walter Holthaus, 4852 Hazelwood Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Peritonitis
188X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Dehiscence of enteroanostomosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1810 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
May 9, 1968 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of bladder | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from May 6, 1968, to May 21, 1968, that (X) (we) last saw the deceased alive on May 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Reynaldo Orjuela Gomez, M.D. | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 21, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/25/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE May 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|---|---|---|---|--|--|---|-------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) HARRY E. HOPKINS, SR. | | | | | | 2a. DATE OF DEATH
Month 9 , Day 1968 | | | 2b. HOUR
11:20 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
October 17, 1890 | | | 6. AGE (In years lost birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Arbutus | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
5513 Link Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired Train Master | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
5513 Link Avenue | | | |
| 14. FATHER'S NAME
First Middle Lost
Unknown | | | | 15. MOTHER'S MAIDEN NAME
First Middle Lost
Unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address Drive
Mr. Harry E. Hopkins, Jr. 1111 Meadow Lark | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular Disease
4120 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 443X
(b) Arterio-sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Hypertension - Diabetes mellitus | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 5/9 , 19 57 , to 5/9 , 19 68 , that (I) (we) lost saw the deceased alive on 5/9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
James N. Frederick | | | | | | 22c. DATE SIGNED
5/10/68 | | 22d. PHYSICIAN'S NAME (Type)
Dr. James N. Frederick | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5-13-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Howard County, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21227 | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

1982

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (1)
30M REV. 7-68

MEDICAL CERTIFICATION

| MAY 21 1968 | | | | | | | | | | MAY 21 1968 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) EDGAR Joseph HOWELL | | | | | | | | | | 2a. DATE OF DEATH Month May Day 21 Year 1968 | | | | | | | | | |
| SEX Male 4. RACE White 5. DATE OF BIRTH May 21, 1968 | | | | | | | | | | 6. AGE (In years last birthday) Newborn 7. IF UNDER 1 YEAR MONTHS 3 DAYS 23 8. IF UNDER 24 HRS. HOURS 12 MIN. 45 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. COUNTY OF DEATH Baltimore, Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A. 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 1612 Round Hill Rd. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First William Middle W. Last Howell, SR 15. MOTHER'S MAIDEN NAME First Jane Middle F. Last O'Hara | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> (If yes give war or dates of service) - 16b. SOCIAL SECURITY NO. - 17. INFORMANT MR. MRS W^m W. HOWELL, SR. Address 1612 Round Hill Rd. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
776.2
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Respiratory distress syndrome
DUE TO, OR AS A CONSEQUENCE OF
(b) Respiratory distress syndrome
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
7735 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that 10 (this hospital) attended the deceased from 5/21/ , 19 68 , to 5/21/ , 19 68 , that (X) (we) last saw the deceased alive on 5/21/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Imelda B. Salanio, M.D. DEGREE M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED May 21, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Imelda B. Salanio, M.D. | | | | | | | | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE MAY 23/1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY GARDENS | | | | | 23d. LOCATION (City or Town) (County) (State) COCKEYSVILLE BALTO. MD. | | | | |
| 24. FUNERAL DIRECTOR H. SANDER & SONS, BALTO. MD. | | | | | | | | | | 25a. REC'D BY REGISTRAR MAY 24 1968 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

81-11674

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | |
|---|-------------------------|--|--|
| 06692 | | 06699 | |
| 1. DECEASED-NAME
(Type or print) Edward A. Hoyt | | 2a. DATE OF DEATH
Month May Day 1 Year 1968 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
May 10, 1896 | |
| 6. AGE (In years last birthday) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
326 Carroll Island Road | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Penn. R. R. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. CITY OR TOWN Baltimore | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
326 Carroll Island Road | |
| 14. FATHER'S NAME First Middle Last
Edward Hoyt | | 15. MOTHER'S MAIDEN NAME First Middle Last
Cynthia Wiedner | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
717-07-7766 | |
| 17. INFORMANT Address
Mrs Clara Hoyt 326 Carroll Island Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro Vascular Thrombosis
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic C.V. Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4-29-68
4-26-68
1966 | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 None | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. TIME OF INJURY
HOUR A.M. Month Day Year
None | |
| 21a. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
None | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
None | | 21d. LOCATION Street or R.F.D. No. City or Town County State
None | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1968 to May 1, 1968 , that (I) (we) last saw the deceased alive on 4-30-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
E. A. Schimunek MD | | 22c. DATE SIGNED
5-3-68 | |
| 22d. PHYSICIAN'S NAME (Type or print)
EMMANUEL A SCHIMUNEK MD | | 22e. ADDRESS
8428 East Ave Baltimore Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-4-1968 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart | | 23d. LOCATION (City or Town) (County) (State)
Baltimore County, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS
Lilly & Zeiler Inc. 1901 Eastern Ave. | | 25a. REC'D BY REGISTRAR
MAY 3 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

17

Baltimore County

1959

Book Order: 11/20/92 258

Palmer's Company, Weymouth

...and the other side of the mountain...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|-----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Barbara K HUBER | | | | | | 5 Month 23 Day 68 Year | | 9:30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| f | | W | | 7-6-1893 | | | 74 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Baltimore Co. | | U.S.A. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bradshaw | | | Phila. Rd. Bradshaw | | | Housewife | | Housewife | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Baltimore | | Perry Hall | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Hall Box 124 Belair Rd. Perry | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| John Kahn | | | Kundagunda Engelhart | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | 215-36-8296D | | Mrs Marie Venzke | | Box 124 Bradshaw 21021 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac failure</u> | | | | | | | | | 2 weeks | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | 18 months | |
| (b) <u>Repeated myocardial infarction</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) <u>ACVD, Obesity</u> | | | | | | | | | several years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/12/54</u> 19 <u>68</u> , to <u>5/23/68</u> 19 <u>68</u> , that (I) (we) lost | | | | | | | | | | |
| saw the deceased dying on <u>May 23</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | |
|  | | | | | | | | 5/24/69 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| RICHARD R. RIGLER, M.D. | | | | 1 W. Overlea Ave., Balto, Md. | | 21206 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5-27-1968 | | Gardens of Faith Cem. | | Baltimore Co. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lassahn Funeral Home 7401 Belair Road 21236 | | | | DATE MAY 29 1968 | |  | | | | |

MEDICAL CERTIFICATION

00130

RECEIVED - JAN 1963

00330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD6695

06701

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) MARELL ELIZABETH HUBER | | | 2a. DATE OF DEATH
Month 5 Day 4 Year 68 | | | 2b. HOUR
12:05 AM | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
3-19-94 | | 6. AGE (In years last birthday)
74 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
BALTO. MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
BALTO. MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CREATON BALTO. MED. CENTER | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
BALTO. Pikesville | | 13c. CITY OR TOWN
BALTO. Pikesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
(21139) | | 14. FATHER'S NAME First Middle Last
Thomas George MAIRS | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nora MACHILLIAMS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
918-32-1095 | | 17. INFORMANT JOHN N. ALEXANDER Address MACHILLIAMS (PATIENT'S CHART) (SAME) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory failure
188X
DUE TO, OR AS A CONSEQUENCE OF
(b) Caf bladder
DUE TO, OR AS A CONSEQUENCE OF
(c) septicemia & septic shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1810 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/28 , 19 68 , to 5/4 , 19 68 , that (I) (we) last saw the deceased alive on 5/4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
P. Navidi | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/4/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Parviz Navidi | | 22e. ADDRESS
G.B.M.C., Towson, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-6-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION (City or Town) (County) (State)
Pikesville Md. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. | | | | 25a. REC'D BY REGISTRAR
MAY 6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

08704

REPUBLIC OF DENMARK

08704

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Dr. Poul Hennrich

Dr. Poul Hennrich

Dr. Poul Hennrich

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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| 06696 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 08091 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Henry E. Hudgins | | | | | | | | | | 5 Month 20 Day 68 Year | | | | | | | | | | 9:55 PM | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS. | | | | |
| Male | | | | | Cau | | | | | 1904 | | | | | 64 YRS. | | | | | MONTHS | | | | | DAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| Baltimore Md | | | | | U.S. | | | | | | | | | | Baltimore Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Maryland | | | | | Greater Balto. Medical Center | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md | | | | | | | | | | Balto. | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 1643 A Waverly | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Joseph E Hudgins | | | | | Mary G Hughes | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| | | | | | 090-07-3022 | | | | | Ruth R Hudgins Waverly | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Metastatic carcinoma of brain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1489 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 147X (b) Primary carcinoma of hypopharynx | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Volvulus of intestine with intestinal obstruction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/19, 19 68, to 5/20, 19 68, that (I) (we) last saw the deceased alive on 5/20, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE John E. Adams | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 5/20/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D. | | | | | | | | | | 22e. ADDRESS 6701 N. Charles Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | | | | 23b. DATE | | | | | 23c. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | |
| Cremation | | | | | 5-22-68 | | | | | LOU DON PK. | | | | | BALTO. MD. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Wm. J. Sicker & Sons | | | | | | | | | | ADDRESS Balto Md. | | | | | 25a. REC'D BY REGISTRAR DATE JUN 19 1968 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |

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John S. Adams

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06697

06702

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Willie Hunley | | | 20. DATE OF DEATH
Month May Day 23 Year 1968 | | | 25. HOUR
2:45 P. M | |
| 3. SEX
male | | 4. RACE
Negro | | 5. DATE OF BIRTH
1892 | | 6. AGE (In years last birthday)
76 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Catonville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3130 Washington Bld. | |
| 14. FATHER'S NAME First Middle Last
unknown | | | 15. MOTHER'S MAIDEN NAME First Middle Last
unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
485X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk. |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that he (this hospital) attended the deceased from Jan. 18, 1968 , to May 23, 1968 , that it (we) last saw the deceased alive on May 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Anthony J. Young, M.D. | | | | | | 22c. DATE SIGNED
5-23-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-28-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Int Admire Cat | | 23d. LOCATION (City or Town) (County) (State)
Balto Md | |
| 24. FUNERAL DIRECTOR
Clay Wilson 1000 B North Ave | | | | 25a. REC'D. BY REGISTRAR
DATE MAY 23 1968 | | 25b. REGISTRAR'S SIGNATURE
John G. Jones | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06698

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06703

| | | | | | | | | | | | | | | | | | |
|---|--|---------------------|----------------------|---|--|---|--|---|-----------------------|--|--|---|--|--|--|----------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
John | | | Middle
A. | | | Last
Hurley | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month May Day 6 Year 1968 | | | | 2b. HOUR
18:35 M | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
9/2/1896 | | 6. AGE (In years last birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | 2c. DATE PRONOUNCED DEAD
Month May Day 6 Year 1968 | | | | 2d. HOUR
18:35 M | |
| 7a. BIRTHPLACE (State or foreign country)
Washington | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Baltimore | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Mechanic | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE
Md. | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
612 Hollen Rd. | | | | | |
| 14. FATHER'S NAME
First
Joseph Middle
Hurley Last | | | | | | 15. MOTHER'S MAIDEN NAME
First
Eagan Middle
? Last | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unknown)
Yes | | | | 16b. SOCIAL SECURITY NO.
W.W.1 577 01 5157 | | 17. INFORMANT
Leota M. Hurley ADDRESS
612 Hollen Rd. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion Sudden
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 24 years | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)
4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | | ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
5/6/68 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
May 9, 68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Va. | | | | | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. 21204 | | | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR
MAY 8 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
HANNAH AMANDA HUTSON | | | 2a. DATE OF DEATH
Month Day Year
5 31 68 | | | 2b. HOUR
M
6 | | | |
| 3. SEX
Female | | 4. RACE
CAU | | 5. DATE OF BIRTH
10-14-87 | | 6. AGE (In years last birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Baltimore Medical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Towson, Md | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
5502 Maryland Ave., #121 | |
| 14. FATHER'S NAME First Middle Last
Wm H HUTSON | | 15. MOTHER'S MAIDEN NAME First Middle Last
Alice R Oliver | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
217-01-4996A | | 17. INFORMANT
PATIENT'S CHART Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
4120
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive and arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
443X Anemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 68 , to 5/31 , 19 68 , that (I) (we) last saw the deceased alive on 5/31 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Keiffer Mitchell | | DEGREE
M.D. | | ATTENDING PHYS.
<input type="checkbox"/> | | MED. DIRECTOR
<input type="checkbox"/> | | STAFF PHYS.
<input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED
5/31/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Keiffer Mitchell M.D. | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Calvary M.E. Church Cem. | | 23d. LOCATION (City or Town) (County) (State)
Harford Md. | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home
Balto., Md. 21212 | | | | 25a. REC'D BY REGISTRAR
DATE JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
John J. Jones | | | |

08706

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Carbide-acetylene welding
equipment and accessories for the
United States Navy

Acetylene

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Emil | | | First R. | | | Middle Jahnke | | | Last | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
Dec. 15, 1891 | | | 2a. DATE OF DEATH
Month May Day 31 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3821 Annadale Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Labor - Chesapeake Paper Mill | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN
Dundalk | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
First Adolph Middle Jahnke Last Blescke | | | 15. MOTHER'S MAIDEN NAME
First Henrietta Middle Blescke Last Blescke | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown Yes (If yes give war or dates of service) WWI | | | 16b. SOCIAL SECURITY NO.
219-16-4203 | | |
| 17. INFORMANT
(Wife) | | | Address Dundalk, Md. | | | Mrs. Anna Jahnke, 3821 Annadale Road | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) A.S.C.V. Disease with chronic failure
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary artery disease due to A.S.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 years
" " | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1962 , to May 31, 1968 , that (I) (we) last saw the deceased alive on May 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ataollah Golpira | | | M.D. DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
5/31/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Ataollah Golpira | | | M.D. | | | 22e. ADDRESS
1942 Cedar Lane, Dundalk, Md. 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
6/3/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
John J. Duda | | | ADDRESS
7922 Wise Ave. Dundalk, Md. | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | | 25b. REG. EXE. SIGNATURE
John J. Duda | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1544
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Paul Eli Jakimovitz | | | | | 2a. DATE OF DEATH Month Day Year
May 22 1968 | | | 2b. HOUR
2 p M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
July 20, 1888 | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | | | |
| 10. CITY OR TOWN OF DEATH
Reisterstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bent Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Glyndon | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
209 Central Avenue | |
| 14. FATHER'S NAME First Middle Last
Unknown | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
213-01-9635 | | 17. INFORMANT Address
Mrs. Mary Jakimovitz Osley Lane Reisterstown Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerosis - generalized</u>
440.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4500 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 10, 1966, to May 22, 1968, that (I) (we) last saw the deceased alive on May 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Clarence E. McWilliams | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 23 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Clarence E. McWilliams | | | | 22e. ADDRESS
11904 Reisterstown Rd Reisterstown Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Trinity Orth. Cem., | | 23d. LOCATION (City or Town) (County) (State)
Howard Co., Md. | | | |
| 24. FUNERAL DIRECTOR
H. J. Schhardt | | | | ADDRESS
Owings Mills, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

08700

DEPARTMENT OF DEATH

000000

1

DATE OF DEATH: 1968-08-22

TIME OF DEATH: 10:30 AM

PLACE OF DEATH: ...

CAUSE OF DEATH: ...

MANNER OF DEATH: ...

DEATH CERTIFICATE NO. ...

REGISTRATION NO. ...

...

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06702

06707

| | | | | | |
|---|-------------------------|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Violette Hammon Jennings | | | 2a. DATE OF DEATH
Month May , Day 15 , Year 1968 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Jan. 17, 1900 | | 6. AGE (In years last birthday)
68 YRS. | IF UNDER 1 YEAR
MONTHS 00 DAYS 30 |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Co. Md. |
| 10. CITY OR TOWN OF DEATH
Baltimore city | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3506 Woodmoor Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Receptionist | 12b. KIND OF BUSINESS OR INDUSTRY
Banking |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
— | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
2708 Auchontorolly Terr. |
| 14. FATHER'S NAME
First Middle Last
George Jennings | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Hammon | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
Mr. Ellsworth Ott Address
3506 Woodmoor Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-genic carcinoma with metastases
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterio-sclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 31 - Thrombo-phlebitis Rt. leg. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 mo.
2 yrs.
3 mo. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
1621 | | | | | |
| 19a. DATE OF OPERATION
1621 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 7 , 19 68 , to May 15 , 19 68 , that (I) (we) last saw the deceased alive on May 15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Earl L. Chambers M.D. | | | | 22c. DATE SIGNED
5/17/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Earl L. Chambers - M.D. | | | | 22e. ADDRESS
4108 Liberty Hts Balto - Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 24. FUNERAL DIRECTOR
Frank A. Senty | | ADDRESS
814 W 36th St Balto Md | | 25. REC'D BY REGISTRAR
20 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. ... | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2070

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06702

06708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|-----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> | | c. LENGTH OF STAY IN TB <u>60 years</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Quaker Bottom Rd</u> | | d. STREET ADDRESS <u>Quaker Bottom Rd</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Edward Johnson</u>
First Middle Last | | 4. DATE OF DEATH <u>May 1 1968</u>
Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-27-1887</u> |
| 9. AGE (In years lost birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Quarry</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Sparks Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Sophia</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-4-9880</u> | |
| 17. INFORMANT <u>wife-Minnie</u> Address <u>Saul</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
4369 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Cerebral arteriosclerosis</u>
DUE TO
(c) <u>20 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 19 1968</u> to <u>May 1 1968</u> , that (I) (we) lost the deceased alive on <u>May 1 1968</u> , and that death occurred at <u>7:10 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Walter T. Kees</u> | | 22b. DATE SIGNED <u>1 May 1968</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u> | | 22d. ADDRESS <u>Cockeyville Md 21030</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5-5-68</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Stevenson A.M.E. Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Sparks Md</u> | |
| 24. FUNERAL DIRECTOR <u>Morton & Dyett F.H.</u> | | 25a. REC'D BY REGISTRAR <u>3 1968</u> | |
| ADDRESS <u>1701 Laurens St</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

10730

CERTIFICATE OF SALE

10730

[Faint, illegible text, likely a certificate of sale or deed, covering the majority of the page.]



3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

3

1

06704

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06709

| | | | | | | | | | | |
|--|---------|---|---|---|--|--|--|---|--------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
p. M. | | | |
| Elizabeth Johnson | | | | | May 4, 1968 | | 9:45 p. | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| female | Negro | | Oct. 14, 1915 | | 52 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| S. C. | | U. S. A. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | domestic | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2733 West Fairmount Avenue | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Glen | | | | Halley | Gussie | | | | Hall | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| Yes, no, or (unknown) | | 223-09-7798 | | Records: SPRING GROVE STATE HOSPITAL | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
412.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
vascular ht. Disease.
Hypertensive, Arteriosclerotic, cardio- | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 yrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 30, 1968, to May 4, 1968, that (I) (we) last
saw the deceased alive on May 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Anthony J. Young, M.D. | | | | | | 22c. DATE SIGNED
5-6-68 | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5-9-68 | | Rehoboth Mem. Ch. Baltimore | | Md. | | | | |
| 24. FUNERAL DIRECTOR
Address | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Wilmington S. Phelps 1727 N. Mount | | | | MAY 15 1968 | | Charles Judge | | | | |

0520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 141 (M) 1
30M REV 10-68

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
|--|--|---------|--|--|--|--------|--|--|--|--------------------------|--|--|--|--|--|--------|--|------|--|
| INEZ H. JOHNSON | | | | | | | | | | MAY 31 1968 | | | | 4:40 A.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| F | | W | | 6/14/1878 | | | | 89 YRS. | | MONTHS | | DAYS | | HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | |
| Md. | | | | U.S.A. | | | | | | | | BALTIMORE Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Catoonsville | | | | Summit Nursing Home | | | | Housewife | | | | Own Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| md. | | | | Balto. | | | | Maryland Line | | | | YES | | York Rd. | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First | | Middle | | Last | |
| Hiram H. Atkinson | | | | | | | | | | Inez Heathcote | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | | 17. INFORMANT | | | | Address | | | | | | | |
| No. | | | | 199-24-7636 | | | | Albert S. Johnson | | | | Maryland Line, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> | | | | | | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 4221 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1967, to 5/31, 1968, that (I) (we) lost the deceased on 5/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | | | |
| E. KASARI'S, M.D. | | | | | | | | | | | | 5/31/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| E. KASARI'S, M.D. | | | | BALTIMORE, MD 21228 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | 6/3/68 | | | | Maryland Line Cem. | | | | Maryland Line, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| James Hartenstein | | | | New Freedom, Pa. | | | | JUN 5 1968 | | | | James Judge | | | | | | | |

07700

RECEIVED

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(M)

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

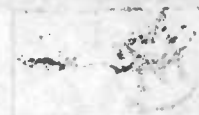
| <div style="display: flex; justify-content: space-between;"> 06706 MARYLAND STATE DEPARTMENT OF HEALTH 06711 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--------------------------------|----------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
ALBERT | | | Middle
WARFIELD | | | Last
JONES | | | 2a. DATE OF DEATH
Month 5 Day 1 Year 68 | | | 2b. HOUR
6:25 PM | | |
| 3. SEX
MALE | | | 4. RACE
NEGRO | | | 5. DATE OF BIRTH
7/20/12 | | | 6. AGE (In years last birthday)
55 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VEI. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SHIPPING CLERK | | | 12b. KIND OF BUSINESS OR INDUSTRY
FURNITURE CO. | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
902 W. Lexington Street | | | | | |
| 14. FATHER'S NAME
First THOMAS Middle JONES Last JONES | | | 15. MOTHER'S MAIDEN NAME
First ELLA Middle COOK Last COOK | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES (If yes give war or dates of service) WW II | | | 16b. SOCIAL SECURITY NO.
218 07 76 33 | | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
150X
DEATH OF XXXXXXXXXXXX
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) POST OPERATIVE STATE ESOPHAGOGASTROSTOMY
DUE TO, OR AS A CONSEQUENCE OF
(c) SURGICAL ABSENCE PARTIAL ESOPHAGUS (SQUAMOUS CELL CARCINOMA) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
RECENT
RECENT | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
150X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that Dr. (this hospital) attended the deceased from 4/5/68 , 19__, to 5/1/68 , 19__, that 1 (we) last saw the deceased alive on 5/1/68 , 19__, and that in (M) (aur) apinian death occurred on the date and hour and from the causes stated above, 1 (we) (did) (does) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
George C. McElpatrick, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED
5/2/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
GEORGE C. McELPATRICK, M. D. | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
5/8/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS
CHARLES L RICE FUNERAL HOME | | | 25a. REC'D BY REGISTRAR
6 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |
| W. BARRE STREET, BALTIMORE, MARYLAND | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

(178)

MADE TO ORDER

COYD



| NAME | AGE | SEX | RELATION | OCCUPATION |
|----------|-----|-----|----------|--------------|
| JOHN DOE | 35 | M | HUSBAND | FARMER |
| JANE DOE | 32 | F | WIFE | HOUSEWIFE |
| JOHN DOE | 10 | M | SON | SCHOOL CHILD |
| JANE DOE | 8 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 5 | M | SON | SCHOOL CHILD |
| JANE DOE | 3 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 2 | M | SON | SCHOOL CHILD |
| JANE DOE | 1 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |
| JOHN DOE | 0 | M | SON | SCHOOL CHILD |
| JANE DOE | 0 | F | DAUGHTER | SCHOOL CHILD |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|---|---|--|---|--|--------------------------------------|---|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Sarah | | | First N. Middle Jones | | | 2a. DATE OF DEATH
Month 5 Day 19 Year 68 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
7-19-94 | | | 6. AGE (In years
last birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country) Ky. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Co. Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Balto. Co. Gen. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
457 Caledonia Ave. | |
| 14. FATHER'S NAME
George | | | First Middle Lost
Reeves | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
XXXXXXXX Amanda Hamlin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO.
404-28-3838 | | 17. INFORMANT
Address
Mr. Bailey Jones, 515 Oella Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
<u>4109</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>4201</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> , 19 <u>68</u> , to <u>May 19</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>11 A.M. 5/19/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Deo Gracias V. Faustino, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
<u>5/19/68</u> | | |
| 22d. PHYSICIAN'S
NAME (Type) <u>DEO GRACIAS V. FAUSTINO, M.D.</u> | | 22e. ADDRESS
<u>Balto. County, Penn. Mary. Randallstown, Md.</u> | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
5-22-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

MEDICAL CERTIFICATION

00118

00501

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and is intended to give a general impression of the work done and the progress made.

2. The second part of the report deals with the details of the work done during the year. It is a detailed account of the work done and is intended to give a detailed impression of the work done and the progress made.

3. The third part of the report deals with the results of the work done during the year. It is a summary of the results of the work done and is intended to give a general impression of the results of the work done and the progress made.

4. The fourth part of the report deals with the conclusions of the work done during the year. It is a summary of the conclusions of the work done and is intended to give a general impression of the conclusions of the work done and the progress made.

5. The fifth part of the report deals with the recommendations of the work done during the year. It is a summary of the recommendations of the work done and is intended to give a general impression of the recommendations of the work done and the progress made.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>06703</div> <div> <div>6713</div> <div> <div>6713</div> <div>06713</div> </div> </div> | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) WILLIAM C. JUNGBLUT | | | | | | 2a. DATE OF DEATH
Month May Day 19 Year 1968 | | | 2b. HOUR 6:15 MIN M | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
March 27, 1924 | | | 6. AGE (In years lost birthday)
44 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Life Ins. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY <input checked="" type="checkbox"/> | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6226 Tra more Rd. 21214 | | |
| 14. FATHER'S NAME First William Middle C. Last Jungblut | | | | 15. MOTHER'S MAIDEN NAME First Madeline M. Middle Sommerfield Last Sommerfield | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, yes (If yes give year or dates of service) WW 2 | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Edith J. Jungblut | | | Address
(Same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 6 , 19 68 , to May 19 , 19 68 , that (I) (we) last saw the deceased alive on May 19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Nepomuceno
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
5-19-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Jose Nepomuceno, M.D. | | | | | | 22e. ADDRESS
7620 York Road, Baltimore, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/22/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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Intelligence

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ACIS, 3, etc. 0833

etc. 0833

5

Intelligence

Intelligence

Intelligence

Intelligence

(206)

Intelligence

Intelligence

Intelligence

Intelligence



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Henry M. Kaiser</i> | | | | | | 2a. DATE OF DEATH <i>5/7/68</i> Month Day Year | | | 2b. HOUR <i>8P.</i> M | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>January 5, 1888</i> | | | 6. AGE (In years last birthday) <i>80</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore Co.</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Balto. Md.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesapeake Manor Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lithographer</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Lord Balto. Press</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Balto. City</i> | | 13c. CITY OR TOWN <i>Balto. City</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>3900 Northern Pkwy.</i> | |
| 14. FATHER'S NAME First Middle Last <i>John Kaiser</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. <i>215-01-3400</i> | | 17. INFORMANT Address <i>Charlotte M. Kaiser - 3900 Northern Pkwy.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARCINOMA OF THE PROSTATE</i>
<i>185X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 1/2 years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>177X</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1965</i> , to <i>MAY 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>5/5/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Luis J. Elias, M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <i>5/9/68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Luis J. Elias, M.D.</i> | | | | | | 22e. ADDRESS <i>1701 MERIDENE DR.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>5-11-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>John C. Miller Inc - 6415 Belair Rd. - 21206</i> ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE <i>May 15 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

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03703

UNITED STATES DEPARTMENT OF AGRICULTURE

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|------------------|--|--|---|---|---|---|
| 1. DECEASED-NAME
(Type or Print) | | First
Warren | Middle
Edwin | Last
Keehn | 2a. DATE KNOWN OF DEATH
Month 5 Day 20 Year 1968 | | 2b. HOUR
8:35 A.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
12-7-05 | 6. AGE (In years last birthday)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month 5 Day 20 Year 1968 | 2d. HOUR
7:30 A.M. |
| 7a. BIRTHPLACE (State or foreign country)
Pottsville, Pa | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Sparrows Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Plant Dispensary | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Erector | | 12b. KIND OF BUSINESS OR INDUSTRY
Shipbldg | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
Warren Keehn | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Sadie Heimbach | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | |
| 16b. SOCIAL SECURITY NO.
178-01-1733 | | 17. INFORMANT ADDRESS
Clara Eigner Keehn, wife, above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4109</u> Coronary occlusion due to arterio-sclerotic cardio-vascular disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Stat. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> N | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
E | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Melvin B. Davis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
6800 Morningside Road Dundalk, Md. 21222 | | 22b. DATE SIGNED
5-20-68 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
2601 E. Madison St. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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Mr. B. B. B.

Mr. B. B. B.

Mr. B. B. B.

Mr. B. B. B.

Mr. B. B. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) MARY | | | First MARY Middle HELEN Last KELSO | | | 2a. DATE OF DEATH
Month MAY Day 14 Year 1968 | | 2b. HOUR
5:05 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
July 17, 1909 | | 6. AGE (In years last birthday)
58 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5212 Midwood Ave. | |
| 14. FATHER'S NAME First FRANK Middle STOWELL Last STOWELL | | | 15. MOTHER'S MAIDEN NAME First ELIZABETH Middle WILSON Last WILSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
MARY ANN HENRY BALTIMORE, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Metastasis of carcinoma,
174X DUE TO, OR AS A CONSEQUENCE OF (Primary site: Breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 6 , 19 68 , to May 14 , 19 68 , that (I) (we) last saw the deceased alive on May 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Yusup Oh, M.D.</i> | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/14/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Yusup Oh, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
SUNSET MEMORIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
CUMBERLAND, MD. | | | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT | | ADDRESS
CUMBERLAND, MD. | | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

41733

MINUTE OF MEETING

41733

THE BOARD OF DIRECTORS OF THE COMPANY

MEETING HELD ON THE 15TH DAY OF JANUARY 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 06712 MARYLAND STATE DEPARTMENT OF HEALTH 06717 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|---|---|--|
| 1. DECEASED-NAME (Type or print) STEPHEN F. KENDALL | | | | | | 2a. DATE OF DEATH
Month 5 Day 29 Year 68 | | | 2b. HOUR
3:15 AM | | |
| 3. SEX
Male | | 4. RACE
W. | | 5. DATE OF BIRTH
1-21-85 | | | 6. AGE (In years last birthday)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
KENT CTY. MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
GARRISON MD. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
FOXLEIGH N. H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
RETIRED PRESSER | | | 12b. KIND OF BUSINESS OR INDUSTRY
TAILORING | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3029 ADEL AVE. #18 | |
| 14. FATHER'S NAME First Middle Last
JOSEPH Kendall | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
SARAH KNOTTS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
217-01-71244 | | 17. INFORMANT Address
MRS. JOHN NOLLMEYER (SAME) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months
years. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 Chronic Pulmonary Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-8 , 19 68 , to 5-29 , 19 68 , that (I) (we) last saw the deceased alive on 5-29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
David J. Miller | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-29-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
David J. Miller | | | | | | 22e. ADDRESS
Owings Mills, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/1/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Balto. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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UNITED STATES DEPARTMENT OF COMMERCE

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UNITED STATES DEPARTMENT OF COMMERCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | |
|---|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) ELLEN ELIZABETH KING | | | 2a. DATE OF DEATH
Month MAY Day 23 Year 1968 | | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
8-4-03 | | 6. AGE (If years last birthday)
64 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
BALTO MORE Md. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREATER BALTO | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
H-W | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
319-W. 27th ST. | |
| 14. FATHER'S NAME First SAMUEL Middle Bowcher Last | | | 15. MOTHER'S MAIDEN NAME First JULIA Middle SULLIVAN Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
218-10-3101 | | 17. INFORMANT Address
MRS. BETTY COLVIN 319 W. 27th ST. BALTO. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Disseminated Carcinoma of the Stomach
1519
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
151X | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that the (this hospital) attended the deceased from 4-17 , 19 68 , to 5-23 , 19 68 , that it (we) last saw the deceased alive on 5-13 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Jose M. De Leon, MD. | | 22c. DATE SIGNED
5-23-68 | | 22d. PHYSICIAN'S NAME (Type)
JOSE M. DE LEON, MD. | | |
| 22e. ADDRESS
GBMAC | | 22f. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-27-68 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHOLIC CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTO, MD. |
| 24. FUNERAL DIRECTOR
L. Walter Corbin | | ADDRESS
5444 BELAIR RD. | | 25a. REC'D BY REGISTRAR
DATE MAY 28 1968 | | 25b. REGISTRAR'S SIGNATURE
James J. Judge |

1528

1925
1926

2018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-58

7
1
06714
MAY 27 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06720

| | | | | | | | | | |
|--|---------|--|------------------|--|---|--|--|--|--------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Lester | | | NMN | Knox | Month 5 Day 21 Year 68 | | 12:17 PM | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | |
| M | W | | 9-23-16 | | 51 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Ohio | | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | G.B.M.C. | | Mechanist | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | BALTO. | | Baltimore | | | | 64 Star Route 21013 | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost |
| Henry | | | | Knox | May | | | | Graver |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| Yes | | WW II | | 287-07-2932 | | Baldwin Mrs Thelma H. Knox Box 64 Star Route | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621 Ca of lungs
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastasis to bone and
DUE TO, OR AS A CONSEQUENCE OF
(c) Liver | | | | | | | | 6 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
163x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-25-1968, to 5-21-1968, that (I) (we) last saw the deceased alive on 5-21-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR | | STAFF PHYS. | |
| A. PIRNIA | | | | | | | | 5-21-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22c. DATE SIGNED | | | | | |
| A. PIRNIA | | G. B. M. C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 5-24-1968 | | Parkwood Cemetery | | Baltimore | | Co. Md. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Charles Judge | | 7401 Breen Rd. | | DATE MAY 27 1968 | | Charles Judge | | | |

08130

OFFICE OF DEATH

08130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: HOLLENBECK FUNERAL HOME, 4 SECOND AVE., GLOVERSVILLE, NEW YORK

VR 15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) MICHAEL | | First Middle Last | | 2a. DATE OF DEATH
Month 5 Day 13 Year 88 | | 2b. HOUR
10:30PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
8/8/19 | | 6. AGE (In years last birthday)
48 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Little Falls, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ELECTRICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
STEEL CO. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME
First John Middle KONIK Last KONIK | | 15. MOTHER'S MAIDEN NAME
First MARY Middle KONIK Last KONIK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give year or years of service) WW II | | 16b. SOCIAL SECURITY NO.
076 01 92 33 | | 17. INFORMANT
Address CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
157.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARCINOMA OF HEAD OF PANCREAS WITH METASTASIS TO
DUE TO, OR AS A CONSEQUENCE OF REGIONAL LYMPH NODES AND LIVER
(c) REGIONAL LYMPH NODES AND LIVER | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
157X | | | | | | | |
| 19a. DATE OF OPERATION
5/13/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that 1 (this hospital) attended the deceased from 5/8/68 , 19__, to 5/13/68 , 19__, that 1 (we) last saw the deceased alive on 5/13/68 , 19__, and that 1 (our) opinion of death occurred on the date and hour and from the causes stated above, 1 (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Peter V. Juvan</i> | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/13/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
PETER V. JUVAN, M. D. | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 23b. DATE
5/18/68 | | 23c. NAME OF CEMETERY OR CREMATORY
PROSPECT HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
GLOVERSVILLE, NEW YORK | |
| 24. FUNERAL DIRECTOR
<i>Joseph N. Zannino</i> | | ADDRESS
JOSEPH N. ZANNINO FUNERAL HOME | | 25a. REC'D BY
15 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |
| 257 S. CONKLING ST. BALTIMORE, MD. | | | | | | | |

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2:50:07:50:21 AM

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Bayer AG

CONCLUSIONS

INSTITUTIONAL FUNDING FOR R&D

• 1 • N • 1076 • P • 128

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1861. It is a copy of the original letter, and is signed by Abraham Lincoln.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 06716 | | 06722 | |
| 1. DECEASED-NAME
(Type or print)
HENRY | | First Middle Last
KRATZ | |
| 2a. DATE OF DEATH
May 14 Day 1968 | | 2b. HOUR
9:20 PM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
June 6, 1887 | |
| 6. AGE (In years last birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore | | Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET AND NUMBER
3709 Frait Avenue | | | |
| 14. FATHER'S NAME
First Middle Last
Henry Kratz | 15. MOTHER'S MAIDEN NAME
First Middle Last
Molly Bush | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | 16b. SOCIAL SECURITY NO.
216-05-8289 | 17. INFORMANT
Mrs. Anna Kratz | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
519.1
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
527.2 | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 11 , 19 68 , to May 14 , 19 68 , that (I) (we) last saw the deceased alive on May 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Yusuf Oh, M.D. | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
5/14/68 |
| 22d. PHYSICIAN'S NAME (Type)
Yusuf Oh, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE
5-18-1968 | 23c. NAME OF CEMETERY OR CREMATORY
David Ridge Crem. | 23d. LOCATION (City or Town) (County) (State)
Md |
| 24. FUNERAL DIRECTOR
Thelma D. Hoffmann | | ADDRESS
3218 Susan St. | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06717

06723

| | | | | | | | |
|--|--|---|---|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) WILLIAM S. KREAMER | | | 2a. DATE OF DEATH
Month MAY Day 5 Year 68 | | | 2b. HOUR
M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MAR 15-1895 | | 6. AGE (In years
lost birthday) 73 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
DUNDALK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) 100 MARYLAND AVE | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) MILL WRIGHT | | 12b. KIND OF BUSINESS OR
INDUSTRY STEEL | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN DUNDALK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
100 MARYLAND AVE | | | | | | | |
| 14. FATHER'S NAME
First JACOB Middle KREAMER Last | | | 15. MOTHER'S MAIDEN NAME
First J Middle Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES | | 16b. SOCIAL SECURITY NO.
213-07-2453 | | 17. INFORMANT
Address MRS. GERTRUDE KREAMER, 100 MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Insufficiency
3979
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4301 ACHED | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/17 , 19 68 to 5/5 , 19 68 , that (I) (we) last
saw the deceased alive on 5/2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Theo. C. Patterson | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYS. | | 22c. DATE SIGNED
5/6/68 | |
| 22d. PHYSICIAN'S
NAME (Type) THEO. C. PATTERSON | | | | 22e. ADDRESS
105 Main | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) BURIAL | | 23b. DATE
MAY 9, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
ADDRESS ULLRICH FUNERAL HOME - DUNDALK MD | | | | 25a. REC'D BY REGISTRAR
DATE MAY 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-64)
30M REV. 6-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) JOHN | | | First JOHN Middle WALTER Last KREIS | | | 2a. DATE OF DEATH
5 Month 7 Day 68 Year | | 2b. HOUR
4:10aM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1/22/02 | | 6. AGE (In years
last birthday)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> SER X | | 9. COUNTY OF DEATH
BALTO. Md. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) G.B.M.C. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
retired cab driver | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2647 NO. CHARLES ST. | |
| 14. FATHER'S NAME First JOHN Middle Walter Last C. KREIS | | | 15. MOTHER'S MAIDEN NAME First CATHERINE Middle SCHAEFFER Last SCHAEFFER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-22-5394 | | 17. INFORMANT Mrs. G. Laurence Walles
PATIENTS CHART 8 Dunkirk Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1538 RECURRENT ADENO CARCINOMA OF THE COLON
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1538 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/21 19 68 , to 5/7 19 68 , that (I) (we) last
saw the deceased alive on 5/7 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E.R. Soudiyn | | | | DEGREE ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/7/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type) E.R. SOUDIYN | | 22e. ADDRESS
GREATER BALTO., MEDICAL CENTER | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
burial | | 23b. DATE
5/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home
Balto., Md. 21212 | | | | ADDRESS
6500 York Rd. | | 25a. REC'D BY REGISTRAR
DATE MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

00734

00734



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 13 (4)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 06719 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06725 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print)
WILLIAM MILTON KRIEB | | | | | 2a. DATE OF DEATH
May Month 18 Day 1968 Year | | | 2b. HOUR
8:50 AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 18, 1899 | | 6. AGE (In years last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
116 Forest Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
116 Forest Avenue | |
| 14. FATHER'S NAME First Middle Last
Louis T. Krieb | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie L. Cain | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs. Theodore B. Clark, 116 Forest Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u>
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardio Vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT-3, 1958</u> , to <u>MAY 18, 1968</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>MAY 17, 1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harry L. Knipp, MD.</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-20-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Harry L. Knipp | | | | | | 22e. ADDRESS
4116 Edmondson Ave., Balto., Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
5-21-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

MEDICAL CERTIFICATION

4172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| MARY | | | KUBSKI | | | MAY Month 20 Day 1968 | | 8:15 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | |
| Female | | White | | 7-5-1890 | | 77 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| New York NY | | USA | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Garrison, MO | | | Faileigh Nursing Home | | | Seams Press | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | Balto | | Baltimore | | YES | | 8715 SUMMIT ST | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Thomas William | | | Thomas | | | Mary Kuslauskas | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| Yes, no, or unknown | | | 216-09-9185A | | Nursing Home Admission Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 2 metastases | | | | | | | | | 5 years | |
| 1538 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 1538 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | |
| | | 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3, 1968, to 5-20, 1968, that (I) (we) last saw the deceased alive on 5-19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | |
| David J. Miller DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 5-20-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| David J. Miller | | | | Linson Rd., Owings Mills, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Buried | | 5/24/68 | | Moreland Memorial | | Parkville, Balto. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| C. F. EVANS & SON 8802 Harford Road | | | | DATE MAY 22 1968 | | Charles Judge | | | | |

00780

DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 510
30M REV. 11-68

| <div style="text-align: center;"> <div>06721</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06727</div> </div> | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Minnie | | | First F. Middle F. Last Kuhn | | | 2a. DATE OF DEATH
Month May Day 29 Year 1968 | | | 2b. HOUR
10:35 AM | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
July 4, 1881 | | | 6. AGE (In years last birthday)
86 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY HXXS. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2230 Wilkins Avenue | |
| 14. FATHER'S NAME First Charles Middle Somers Last | | | | 15. MOTHER'S MAIDEN NAME First Margaret Middle Kane Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO.
 | | 17. INFORMANT Address
Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism, massive, presumptive,
4549
DUE TO, OR AS A CONSEQUENCE OF
(b) Thrombophlebitis, presumptive,
DUE TO, OR AS A CONSEQUENCE OF
(c) Varicose Veins, bilateral, moderate
460X
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE last: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate

unknown

20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senile. | | | | | | | | | | |
| 1) Arteriosclerotic Cardiovascular Ht. D.s. 2) Arteriosclerosis, Gen. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Dec. 29, 1964 , to May 29, 1968 , that (X) (we) last saw the deceased alive on May 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Anthony J. Young, M.D. | | | | | | | | 22c. DATE SIGNED
5-29-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
6-3-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

06737

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06737

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Page 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--------|---|--|---|----------------------------|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) EDMUND, JR. | | First F. | Middle | Lost | 2a. DATE OF DEATH
Month May Day 21 Year 1968 | | 2b. HOUR
5:15 PM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
April 21, 1955 | | 6. AGE (In years
lost birthday) 13 YRS. | | IF UNDER 1 YEAR
MONTHS 13 DAYS 13 | | IF UNDER 24 HRS.
HOURS 13 MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) Student | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5925 Benton Heights Ave. | | | |
| 14. FATHER'S NAME
Edmund F. | | First Kwiatkowski Jr. | | Lost | | 15. MOTHER'S MAIDEN NAME First
Kathleen | | Middle
Martin | | Lost | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
212-50-3539 | | 17. INFORMANT
E. F. Kwiatkowski Sr. | | Address
same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant tumor of testicle with massive metastasis.
186X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a).
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
178X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 25, 1968 , to May 21, 1968 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on May 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence F. Misanik, M.D. | | DEGREE | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 22, 1968 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5/21/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Com. | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

2520

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06722

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| | | | | | | | |
|---|--|---|-------------------------|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY DELAVAR | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | c. LENGTH OF STAY IN TB | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mercy Villa Nursing Home | | | | d. STREET ADDRESS
511 E. 39th Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Elizabeth Last Lacey | | | | 4. DATE OF DEATH
Month May Day 28 Year 19 68 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 17, 1875 | |
| | | | | 9. AGE (In years lost birthday)
92 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John Cochran | | | | 14. MOTHER'S MAIDEN NAME
Mary King | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
220 44 4369 | | 17. INFORMANT
Sister M. Carlotta, R.S.M. 6400 Ballona Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (1) Arterio Sclerotic Heart Disease
DUE TO 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arterio Sclerosis
DUE TO -
(c) - | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
4200 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (H) (this hospital) attended the deceased from 11/12 , 19 64 , to 5/28 , 19 68 , that (H) (we) last saw the deceased alive on 5/24/68 19 68 , and that death occurred at 10:35 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Earl L. Chambers | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/28/68 | |
| 22c. PHYSICIAN'S NAME (Type)
Earl L. Chambers | | | | 22d. ADDRESS
4108 Liberty Hts Ave Balto Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/31/68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Church | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co | | | | ADDRESS
4905 York Road Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
MAY 31 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|--|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) JOHN W. LANCASTER | | 2a. DATE OF DEATH
Month 5 Day 1 Year 68 | | 2b. HOUR
7:40P M |
| 3. SEX
MALE | 4. RACE
NEGRO | 5. DATE OF BIRTH
5/29/07 | | 6. AGE (In years last birthday)
60 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
TRUCK DRIVER | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
902 FRANKLINTOWN ROAD |
| 14. FATHER'S NAME First JOHN Middle W. Last LANCASTER | | 15. MOTHER'S MAIDEN NAME First SUSIE Middle GREEN Last GREEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown YES (If yes give year or dates of service) WW II | | 16b. SOCIAL SECURITY NO.
217 07 46 04 | | 17. INFORMANT Address
CLIN.RECORDS, VA HOSPITAL, FT. HOWARD, MD. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG ABSCESS, RIGHT WITH EMPYEMA
513X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 521X
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
BRONCHOPNEUMONIA. ARTERIOSCLEROTIC HEART DISEASE | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WEEKS |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year 19
P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ |
| 22a. I certify that (X) (this hospital) attended the deceased from 4/29/68 , 19____, to 5/1/68 , 19____, that (X) (we) last saw the deceased alive on 5/1/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (does) view the body after death. | | | | |
| 22b. SIGNATURE
John D. Talbert MD DEGREE _____ ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/2/68 |
| 22d. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
May 16, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
JOSEPH L. RUSS FUNERAL HOME
2222 W. North Ave. Balto. | | 25a. REC'D BY REGISTRAR
MAY 3 1968 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge |

5320

| Age Group | 1970 | 1980 | 1990 | 2000 | 2010 | 2020 |
|-----------|------|------|------|------|------|------|
| 0-14 | 18% | 16% | 14% | 12% | 10% | 8% |
| 15-24 | 12% | 11% | 10% | 9% | 8% | 7% |
| 25-34 | 10% | 9% | 8% | 7% | 6% | 5% |
| 35-44 | 8% | 7% | 6% | 5% | 4% | 3% |
| 45-54 | 6% | 5% | 4% | 3% | 2% | 1% |
| 55-64 | 4% | 3% | 2% | 1% | 0% | 0% |
| 65+ | 2% | 3% | 4% | 5% | 6% | 7% |

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WILLIAMS, J. 1992. 209.

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UNIVERSITY OF CALIFORNIA, LOS ANGELES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

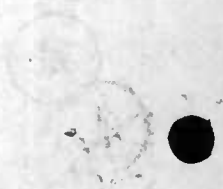
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Mary Elizabeth LANIGAN | | | | | | Month Day Year
May 2, 1968 | | | 12:15 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | November 9, 1913 | | | 54 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Baltimore, Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | ST. JOSEPH HOSPITAL | | | Homemaker | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1143 Donnington Circle | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Joseph S Meagher | | | Dorothea A Lutz | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | 231-26-0377 | | Joseph P Lanigan | | Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u>
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes mellitus</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260x | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 4/22/68
4/23/68 | | Peripheral vascular disease
Gangrene left leg | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4/4/</u> , 19 <u>68</u> , to <u>5/2/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>5/2/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Benjamin del Carmen</u> DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 2, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Benjamin del Carmen, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5/6/68 | | Dulaney Valley | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Leonard J Ruck Inc Baltimore, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 3 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | | |

23730

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10/10/50



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>06726</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06732</div> | | | | | | | | | | | | |
|--|------------------|--|---|---|--|--|--|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or Print) Sarah Ann LANTZ | | | | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year 5-18 1968 | | | 2b. HOUR 10:30 A.M. | | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH 4/21/22 | 6. AGE (In years last birthday) 46 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month Day Year May 18 1968 | | | 2d. HOUR 11:30 A.M. | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Arbutus | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5509 Ashbourne Rd | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 5509 Ashbourne Rd | | | |
| 14. FATHER'S NAME First Middle Last Milton Lantz | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Iva Pauline Willard | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 220-18-1560 | | 17. INFORMANT Mrs. Iva P. Lantz | | | ADDRESS Lantz, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular Disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE James N. Frederick M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED 5/18/68 | | | | |
| EXAMINER'S NAME (Type) James N. Frederick | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 1311 Francis Ave
ADDRESS (Street, city, town, or county) Balto. Md 21227 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-22-68 | | 23c. NAME OF CEMETERY OR CREMATORY United Brethren Cem. | | | | 23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR Raymond E. Creager ADDRESS Thurmont, Md. | | | | 25a. REC'D BY REGISTRAR MAV 21 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

86730

86730

1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A10 (1)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|---|---|--|---|--|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) ANNE M LARKIN | | | | | | 2a. DATE OF DEATH MAY Month 7 Day 1968 | | | 2b. HOUR 6:00 M | | |
| 3. SEX fe | | 4. RACE white | | 5. DATE OF BIRTH 5-21-1891 | | | 6. AGE (In years lost birthday) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Balto. MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Carrison, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Foxleigh Conv Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALES LADY | | | 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N Calvert St | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3007 N Calvert St | | |
| 14. FATHER'S NAME First John Middle J Last Larkin | | | | 15. MOTHER'S MAIDEN NAME First ANNE Middle GILCHRIST Last ROAD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 214-12-2972A | | 17. INFORMANT Address MRS. HILDA M. KING, 1301 RAMBLEWOOD ROAD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis, acute
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis with ad
DUE TO, OR AS A CONSEQUENCE OF CVA
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1964 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
4201 Generalized Arteriosclerosis - | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 11-28 , 19 64 , to 5-7 , 19 68 , that we last saw the deceased alive on 5-7 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Rafael Perez-Mena MD | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 5-1-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) RAFAEL PEREZ-MENA | | | | 22e. ADDRESS 7306 LIBERTY ROAD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION (City or Town) Baltimore (County) Maryland (State) | | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | | ADDRESS 4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09619
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print)
Baby Boy | | | First Middle Last
LAWRENCE | | | 2a. DATE OF DEATH
Month May Day 23 Year 1968 | | | 2b. HOUR
11:10 A.M. | | | | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
May 23, 1968 | | | 6. AGE (In years last birthday)
YRS. MONTHS DAYS
5 5 58 | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
4001 Wilsby Ave. | | |
| 14. FATHER'S NAME First Middle Last
Richard Lawrence | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Joyce Drexler | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
N/A | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address
Mother | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
7777X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
776X | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that no (this hospital) attended the deceased from <u>5/23/</u> 19 <u>68</u> , to <u>5/23/</u> 19 <u>68</u> , that <u>4</u> (we) last saw the deceased alive on <u>5/23/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Samuel J. Misanik</i>
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type) LAWRENCE MISANIK | | | | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
7-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
21st Street School | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR
DATE JUL 23 1968 | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(13)

(1)



27 JUN 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13
30M REV. 5-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|---|---|--|
| <div style="display: flex; justify-content: space-between;"> 06728 CERTIFICATE OF DEATH 06734 </div> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Anna | | Middle
M. | | Last
Lee | | 20. DATE OF DEATH
Month Day Year
May 19, 1968 | | |
| 3. SEX
female | | | 4. RACE
white | | 5. DATE OF BIRTH
Aug. 12, 1895 | | | 6. AGE (In years
lost birthday)
72 YRS. | | 2b. HOUR
11:35 a.m. | |
| 70. BIRTHPLACE (State or foreign
country)
Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
SPRING GROVE STATE HOSPITAL | | | 120. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2200 Wilkens Avenue | | |
| 14. FATHER'S NAME
First Middle Last
unknown | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
none | | 212-36-8863 | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) bacteremia
7070 Shock, septic, with septicemia & probable infection
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause
Decubitus ulcer, sacral, with secondary infection
lost. 715 x (b) 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) dial infarction
1) Arteriosclerotic Cardiovascular Ht. Dis. with previous ant. myocar. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1968, to May 19, 1968, that (I) (we) last saw the deceased alive on May 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Anthony J. Young, M.D. | | | | | | 22c. DATE SIGNED
5-20-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
5/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Ritchie Hghw. Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
KRAUSE FUNERAL HOME | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 06729 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06735 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last
CHARLES W. LEE | | | | | | | | | | Month Day Year
5 15 68 | | | | | | | | | | 3:20AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
MALE | | | | | | | | | | 4. RACE
WHITE | | | | | | | | | | 5. DATE OF BIRTH
7/4/92 | | | | | | | | | | 6. AGE (In years last birthday)
75 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CATTLE DEALER | | | | | | | | | | 12b. KIND OF BUSINESS OR OCCUPATION
LIVESTOCK | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | | | | | | | | 13b. COUNTY
BALTIMORE | | | | | | | | | | 13c. CITY OR TOWN
BALTIMORE | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
3012 Vermont Avenue | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
William Lee | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Cecelia Wolf | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES (If yes give war or dates of service) WW I | | | | | | | | | | 16b. SOCIAL SECURITY NO.
216 30 95 44 | | | | | | | | | | 17. INFORMANT Mrs. Edna Mae Reitter, 3012 Vermont Ave., Baltimore, Md. 21227 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC INSUFFICIENCY
398X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/6 X
(b) RHEUMATIC HEART DISEASE, INACTIVE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
SEPTICEMIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 3/18/68 , 19__, to 5/15/68 , 19__, that he (we) last saw the deceased alive on 5/15/68 , 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John D. Talbert, M.D. | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
5/15/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | | | | | | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | | | | | | 23b. DATE
17 MAY 68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDEN PARK NATIONAL | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS
WITZKE FUNERAL HOME | | | | | | | | | | 25a. REC'D BY REGISTRAR
MAY 17 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | DATE
Baltimore, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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APPENDIX

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(UNCLASSIFIED)

THE UNIVERSITY OF CHICAGO

... ..

JANUARY 1951, 1950.

1000 Broadway Ave., Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06730

06737

FOR STATE HEALTH DEPT.

| | | | | | | | | | | | |
|--|---------|------------------------------|--|---|---------------------------|---|---|------------------------------------|--|---|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> Month | Day | Year | 2b. HOUR | |
| Henry Joseph Leibersberger | | | | | 5/31/68 | | | | | 7:45 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
DAYS | 2c. DATE PRONOUNCED DEAD | | Month | Day | |
| Male | Cau | 3/12/00 | | 68 YRS. | | | May 31 | | Year | 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| New York | | USA | | | | Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Catonsville | | | 1010 Collwood Rd | | | Teacher | | | Schools | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md | | | Baltimore | | | Catonsville | | | 1010 Collwood Rd | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | |
| Karl Leibersberger | | | Unknown Graef | | | No | | | 132-07-4394 | | |
| 17. INFORMANT | | | 18. ADDRESS | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| Theresa Leibersberger | | | Same as #13e | | | | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4221</u> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | |
| | | | | | | | | | County | | |
| | | | | | | | | | State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>James N. Frederick</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>5/31/68</u> | | |
| EXAMINER'S NAME (Type) <u>James N. Frederick</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 1311 Francis Ave | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | Balt. 27 md | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | | | | | 6/3/68 | | Lorraine Mausoleum | | Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 6212 Balt. Nat. Pike | | | | | | Wm. Cook-Brooks West Inc | | Balt. Md. 21228 | | JUN 4 1968 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00734

STATE OF TEXAS, COUNTY OF DALLAS

00734

VI

VI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 143 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 20. DATE OF DEATH | | 2b. HOUR | |
| DAVID | | (none) | | LIPSITZ | | (LIPSCHITZ) | | Month 5 Day 11 Year 1968 | | 3:40 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | May 15 1899 | | | | 68 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Russia | | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Candlishon | | | | Baltimore County General | | | | Self-employed | | Retail | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | | | Baltimore | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2923 Marnat Road | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| Harry Lipsitz | | | | | | | | | | Drene Greenfield | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | | 218-32-1634 | | Mrs Esther Lipsitz 2923 Marnat Rd | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4129 E M P T E M A | | | | | | | | | | 5 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CVA | | | | | | | | | | 2 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ASCVD | | | | | | | | | | 29 days 5 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4221 G.I. Bleeding - PARKINSON'S DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/6, 1968, to 5/11, 1968, that (I) (we) last saw the deceased alive on 5/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard Katon M.D. | | | | | | | | | | 22c. DATE SIGNED 5/11/68 | |
| 22d. PHYSICIAN'S NAME (Type) RICHARD KATON | | | | | | | | | | 22e. ADDRESS Balto Co. Gen. Hosp. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/12/68 | | Bair, Lubavitch Tzernich Zedek Shomra Adoni Balto. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Sol Leunand Bushe 6010 Ristratoun Rd | | | | | | DATE MAY 16 1968 | | Charles Judge | | | |

85780

18638

(1150211)

FOR STATE HEALTH DEPT.

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06732

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06739

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print) HENRY R LISTMAN JK | | | 2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> | | |
| 3. SEX Male | | | 4. RACE White | | |
| 5. DATE OF BIRTH 11-6-34 | | | 6. AGE (In years last birthday) 33 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Ind | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Sparrows Point | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethlehem Steel Corp. | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Steam fitter | | | 12b. KIND OF BUSINESS OR INDUSTRY Anth. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Anne Arundel | | |
| 13c. CITY OR TOWN Pasadena | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER 312 Green Laurel Oaks | | | | | |
| 14. FATHER'S NAME Henry A. Listman | | | 15. MOTHER'S MARRIED NAME William F. Humphrey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO. 216306035 | | |
| 17. INFORMANT Ms Leida Listman | | | ADDRESS Above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Traumatic Injuries
921.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
9153 | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year May 3, 1968 | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Explosion while at work | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Buliding | | |
| 21f. LOCATION Street or R.F.D. No. Sparrows Point | | | City or Town Baltimore State M.D. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 5/7/68 | | |
| 23c. NAME OF CEMETERY OR CREMATORY Glen Haven | | | 23d. LOCATION (City or Town) Glen Burnie (County) AA (State) md | | |
| 24. FUNERAL DIRECTOR Robert S. Barranco | | | 25a. REC'D BY REGISTRAR May 7 1968 | | |
| | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

3352

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06732

06740

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Milton A. Lowenberg | | | 2a. DATE OF DEATH
Month 7 Day 2 Year 68 | | | 2b. HOUR
7a M | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
3/27/90 | | 6. AGE (In years last birthday)
78 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
St. Joseph, Mo | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Pikesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Professional House | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Col. (Ret) USA | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
N.Y. | | 13b. COUNTY
Manhattan | | 13c. CITY OR TOWN
N.Y. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
305 West End Ave | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Isaac Lowenberg | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lena Vossen | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes | | 16b. SOCIAL SECURITY NO.
548-34-9849 | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerotic Heart Disease & Congestive Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetic Mellitus | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260x | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr 30, 1968 to May 2, 1968 , that (I) (we) last saw the deceased alive on May 2nd 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M Paul Byerly MD | | | | | | 22c. DATE SIGNED
5/2/68 | |
| 22d. PHYSICIAN'S NAME (Type)
M Paul Byerly | | | | 22e. ADDRESS
5820 York Rd | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
Crema | | 23b. DATE
5/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Landon Park - Arlington | | 23d. LOCATION (City or Town) (County) (State)
Arlington VA | |
| 24. FUNERAL DIRECTOR
Sydney S. Lewis & Son, Inc | | | | 25a. REC'D BY REGISTRAR
MAY 2 1968 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

06734
Item #586 Film #G400 5/20/68 ph

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06741

| | | | | | | | | | |
|--|--|--|--------|---|--|--|--|---|-----|
| 1. DECEASED-NAME
(Type or print) DR. WILLIAM | | First | Middle | Lost | 20. DATE OF DEATH
Month MAY Day 11 Year 1968 | | 2b. HOUR 11:25 | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPTEMBER 24, 1897 | | 6. AGE (In years lost birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN | |
| 7a. BIRTHPLACE (State or foreign country)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE, | | | MD. |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Surgeon-Physician | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
HARFORD | | 13c. CITY OR TOWN
BEL AIR | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
ROUTE # 1, BOX 109 | |
| 14. FATHER'S NAME
First William Middle Lueders Lost | | 15. MOTHER'S MAIDEN NAME
First Rose Middle Hagaman Lost | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) yes (If yes give war or dates of service)
WW#2 | | 16b. SOCIAL SECURITY NO.
266-72-5517 | | 17. INFORMANT (with Address)
Mrs. Rachel L. Lueders BEL Air, Maryland 21014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from MAY 1 , 19 68 , to MAY 11 , 19 68 , that (X) (we) last saw the deceased alive on MAY 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Paglinauan M.D. DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
MAY 11, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
T. PAGLINAUAN, JR., M.D. | | 22e. ADDRESS
7620 YORK ROAD TOWSON, MD. #21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 14, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Darlington Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Darlington Harford Co Maryland | | | |
| 24. FUNERAL DIRECTOR
Joseph William Foster ADDRESS
131 Broadway & Williams St | | | | 25a. REC'D BY REGISTRAR
DATE MAY 16 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

06741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30A REV. 5-68

| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
|--|--|------------------------------|--|---|------------------------------------|---|---|--|--|--|------------------|
| EUGENE J MAGNANI | | | | | | | Month | Day | Year | 7A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | | WHITE | | APRIL 19 1916 | | | 32 YRS. | | MONTHS | DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| RICHMOND VA | | U.S.A. | | | | BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| KINGSVILLE MD | | | 13 SILVER SPRUCE TER | | | SHEET METAL WORKER | | | MARTINS | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | | KINGSVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13 SILVER SPRUCE TERRACE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| EUGENE MAGNANI | | | UNK. | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| YES | | | WORLD WAR II | | | LORETTA A MAGNANI 13 SILVER SPRUCE TER | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> | | | | | | | | | | 10 min | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>arteriosclerotic heart dis</u> | | | | | | | | | | 9 years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 7 PM 5-28-1968 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-26</u> , 19 <u>59</u> , to <u>May 28</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-16</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | |
| <u>W. K. Wong</u> | | | 5/28/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | |
| W. K. WONG | | | 6801 BELAIR RD. 21206 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | MAY 31 1968 | | PARKWOOD CEMETERY | | TAYLOR AVE BALTO MD | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| THE DIPPEC BROS INC 7110 BELAIR RD | | | DATE MAY 31 1968 | | | Charles Judge | | | | | |

MEDICAL CERTIFICATION

1970

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1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---------|--|------------------|------------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Claire Veronica MANTICH | | | | | | Month 5 Day 2 Year 68 | | | 2:05 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Female | | White | | 3/10/54 | | | 14 YRS. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| D. C. | | | U.S.A. | | | | | Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Owings Mills | | | Rosewood State Hospital | | | Dependent | | None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Montgomery | | Silver Spring | | | | 8501 Mayfair Place |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| George James Mantich | | | Lois Luella Meeker | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| no | | | none | | | Rosewood Records, Owings Mills, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral Atelectasis Marked</u>
735X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Tracheal Compression</u>
745X
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Severe Cervical Spinal Stenosis</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Severe Mental Retardation, Anoxic Encephalopathy at Birth</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>terminal</u>
<u>terminal</u>
<u>years</u> |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>1/4</u> , 19 <u>56</u> , to <u>5/2</u> , 19 <u>68</u> , that (we) last saw the deceased alive on <u>5/2</u> , 19 <u>68</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) <u>not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| <u>Richard A. Jones</u> | | | <u>3 May 68</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Richard A. Jones, M.D. | | | Rosewood St. Hosp., Owings Mills, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | May 6, 1968 | | St. John's | | Forest Glen Montgomery Md. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| F.J. COLLINS | | | 3821-14th St. N.W. | | | DATE MAY 7 1968 | | <u>Charles Judge</u> | |

85732

RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|---------|---|------------------|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Arvester | | Marshall | | | Month Day Year
May 12, 1968 | | 10:45 P.M. | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| male | Negro | | May 7, 1919 | | 49 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| North Carolina | | U. S. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Catonsville | | SPRING GROVE STATE HOSP. | | porter | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 110 Arlington Ave. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Lost | | First Middle Lost | | | | | | | |
| William Marshall | | Bertha Trice | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| Yes, no, or unknown | | 1944-45 | | 273-12-7475 | | | | | |
| Army | | | | Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, death,
4109 with previous myocardial infarction
Arteriosclerotic Cardiovascular Ht. Dis. 1 year.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
acute | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Central Nervous System (meningo-vascular) system, treated (Oct. '67) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Sept. 13, 1967, to May 12, 1968, that (X) (we) last saw the deceased alive on May 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S
NAME (Type) | | | | | |
| | | 5-13-68 | | Anthony J. Young, M.D. | | | | | |
| 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | | | | | | | |
| SPRING GROVE STATE HOSPITAL | | Charles Judge | | | | | | | |
| Baltimore, Maryland 21228 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/15-68 | | Glennview Memorial | | Durham N.C. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Burthay Funeral Ser. 1510 Fayetteville St. | | DATE MAY 17 1968 | | | | | | | |

00737

(SIGNED BY THE DIRECTOR)

10:02

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RECEIVED

May 1, 1960

May 1, 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06738

06745

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) JOSEPH A. MARTIN | | | First Middle Last | | | 2a. DATE OF DEATH
5 Month 25 Day 68 Year | | | 2b. HOUR
6:00 P. M. | | |
| 3. SEX
M | | | 4. RACE
W | | | 5. DATE OF BIRTH
11/1/94 | | | 6. AGE (In years last birthday)
74 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTO | | |
| 10. CITY OR TOWN OF DEATH
CATONSVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
15 N. BELLE GROVE | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SER. STA. RET. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
BALTO. CATONSVILLE | | | 13c. CITY OR TOWN
CATONSVILLE | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
Matthew Martin | | | 15. MOTHER'S MAIDEN NAME
Jane Gaffney | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
YES | | | 16b. SOCIAL SECURITY NO.
220-12-6364 | | |
| 17. INFORMANT
TRESSA MARTIN - N. N. Bull | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u>
(b) <u>Arteriosclerotic Cardio-Vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Chronic emphysema</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12ms.
10ys. | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | 22a. SIGNATURE
Wilmer K. Gallagher M.D.
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
5-27-68 | | |
| 22b. PHYSICIAN'S NAME (Type)
Wilmer K. Gallagher | | | 22e. ADDRESS
6209 Frederick Ave. Baltimore, Md. 21228 | | | 22d. I certify that (I) (this hospital) attended the deceased from 2-1-1963, to 5-25-1968, that (I) (we) lost the deceased alive on 5-16-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22f. REGISTRAR'S SIGNATURE
J. J. J. J. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
5/29/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | | |
| 24. FUNERAL DIRECTOR
E.S. MACNABB, CATONSVILLE MD | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | | 25b. REGISTRAR'S SIGNATURE | | | 25c. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
Freida nmi Mayer | | | 2a. DATE OF DEATH Month Day Year
5 25 68 | | 2b. HOUR
7:16 P.M. |
| 3. SEX
Female | 4. RACE
WHITE | 5. DATE OF BIRTH
11/9/82 | | 6. AGE (In years lost birthday)
85 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Germany | 7b. CITIZEN OF WHAT COUNTRY?
USA | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore County Md. | | |
| 10. CITY OR TOWN OF DEATH
Randallstown, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Balto. Co. Gen. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b. COUNTY
Balto ✓ | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
6604 Troy Court | |
| 14. FATHER'S NAME First Middle Last
Samuel Mayer | | 15. MOTHER'S MAIDEN NAME First Middle Last
Caroline Henaline | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | 16b. SOCIAL SECURITY NO.
217-12-6476 | 17. INFORMANT
Mrs. Lee Proger Address
6604 Troy Ct | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural hematoma
887X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 9040
(b) Cerebral concussion
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Fx. right neck humerus, Colle's fracture, right., ASHD, Bronchopneumonia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)
Not while at work <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
5:12 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fell @ Home | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
Home | | 21f. LOCATION Street or R.E.D. No. City or Town County State
6604 TROY COURT 21209 Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-12 , 19 68 , to 5-25 , 19 68 , that (I) (we) lost saw the deceased alive on 5-25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jose A. Raquel, Jr., M.D. | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/25/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS
Balto. County Hosp. Randallstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
5/26/68 | 23c. NAME OF CEMETERY OR CREMATORY
Chesa Alamos Chesa | | 23d. LOCATION (City or Town) (County) (State)
Randallstown Md |
| 24. FUNERAL DIRECTOR
Sylvan S. Lewis & Son, INC 9410 Rusten Rd | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAY 29 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

45760

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-140
30M REV. 1-78

| <div style="display: flex; justify-content: space-between;"> 06740 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06747 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) BERTIS First DEE Middle MCCARROLL Last | | | | | | 2a. DATE OF DEATH 5 31 - 68 Month Day Year | | | 2b. HOUR 6:15 PM | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH 8-6-01 | | | 6. AGE (In years last birthday) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) ARKANSAS | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY Md. Drydock | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND STATE | | | 13b. COUNTY A.A. Co. | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 281 HILLSIDE TERRACE | |
| 14. FATHER'S NAME First William Middle Mc Last CARROLL | | | | 15. MOTHER'S MAIDEN NAME First ELLIE Middle Finley Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO. 185-01-2934 | | 17. INFORMANT Address Records, Mt. Wilson State Hospital | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 337x | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. Newcomer DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | 22e. ADDRESS Mount Wilson, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 6-3-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk. | | | 23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hwy., Baltimore | | | | 25a. REC'D BY REGISTRAR DATE JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

06741

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06748

FOR STATE HEALTH DEPT.

| | | | | | | | | | |
|---|---------------------|---|---|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or Print) THOMAS MARTIN Mc ENROE | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input type="checkbox"/> MONTH DAY YEAR
MAY 14 1968 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | 4. RACE
W | 5. DATE OF BIRTH
Mar 5, 1901 | 6. AGE (in years last birthday)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month May Day 14 Year 1968 | | | 2d. HOUR
M |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. 15 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4700 Ridge Ave. Balt. 15 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
odd jobs | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
4700 RIDGE AVE. |
| 14. FATHER'S NAME
First Peter J. Middle Mc Enroe Last Mc Enroe | | | 15. MOTHER'S MAIDEN NAME
First ANNIE Middle COOLAHAN Last COOLAHAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) World-Two | | | 16b. SOCIAL SECURITY NO.
216-12-2198 | | 17. INFORMANT
Katherine Groscholtz | | ADDRESS
6610 Brighton Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerosis
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) V. Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 1 yr.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 None | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH
None | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M.
19 None | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
None | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
None | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
None | | 21f. LOCATION Street or R.F.D. No.
None | | City or Town
None | | County
None | State
None |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
D. D. Caples | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
5-14-68 | | | |
| EXAMINER'S NAME (Type)
D. D. CAPLES | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ADDRESS (Street, city, town, or county)
Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
G. Vernon Gemmon | | | | ADDRESS
4611 Park Heights Av. Balto. | | 25a. REC'D BY REGISTRAR
DATE
MAY 16 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/10/60

UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AR 1-14
30M REV. 4-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--------------------------|--|--|--|
| 06742 | | 06749 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Lafayette | | J. | | McGuire | | May 29, 1968 | | 9:30 | | P. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | August 4, 1898 | | 69 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| W. Va. | | USA | | | | Baltimore | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Dundalk | | 8014 Gray Haven Rd. | | Engineer--Steel Co. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Balto. | | Balto. | | | | 8014 Gray Haven Rd. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| James | | W. | | McGuire | | | | Lora | | B. Miller | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 213-07-9966 | | Mrs. Sarah B. McGuire | | (Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>San guine</u> | | | | | | | | | | 5 mos. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Buerger's Disease</u> | | | | | | | | | | 5 years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Diabetes M.</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 260x <u>Atherosclerosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1960</u> , to <u>May 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| <u>R. Windsor</u> | | 5-31-68 | | ROGER B. WINDSOR | | 520 DPK | | Balt 19, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 6/3/68 | | Meadowridge Mem. Cem. | | Elkridge, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Leonard J. Ruck, Inc. | | Balto. Md. 21214 | | MAY 31 1968 | | Charles Judge | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15M
30M REV 11-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|--|---|---|--|---|--------------------------|--|
| 06742 | | | | | | | | | | |
| 06750 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | | |
| First Middle Last
FRANKLIN GARRISON MC MANUS | | | | | Month Day Year
5 10 68 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7b. HOUR | | |
| MALE | | WHITE | | 8/18/63 | | 84 | | 3:20AM | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| PENNSYLVANIA | | U.S.A. | | | | BALTIMORE COUNTY, Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| FORT HOWARD | | | VET. ADM. HOSPITAL | | | LABORER | | CENETERY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | BALTIMORE | | YES | | 2312 Pratt Street | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| James McManus | | | | | Levenia Musgrove | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give branch or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| YES | | | WW I | | CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X DUE TO, OR AS A CONSEQUENCE OF COR PULMONALE | | | | | | | | | | |
| 5271 DUE TO, OR AS A CONSEQUENCE OF PULMONARY EMPHYSEMA | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CIRRHOSIS OF LIVER | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 5/6/68 , 19__, to 5/10/68 , 19__, that he (we) last saw the deceased alive on 5/10/68 , 19__, and that we (our) opinion death occurred on the date and hour and from the causes stated above. he (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE J. D. Talbert, MD. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED 5/10/68 | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | | | | 22e. ADDRESS VAH FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 5/13/68 | | BALTIMORE NATIONAL | | | BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR G. Truman Schwab | | | | ADDRESS SCHWAB FUNERAL HOME | | 25a. REC'D BY REGISTRAR DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |
| | | | | 2102 Frederick Ave. Baltimore, Md. | | | | | | |

00000

DATE OF BIRTH

00000

NAME, ADDRESS, CITY, STATE, ZIP, SEX, RACE, RELIGION, OCCUPATION, EDUCATION, MARITAL STATUS, SOCIAL SECURITY NUMBER, DATE OF BIRTH, PLACE OF BIRTH, PARENTS' NAMES, SIBLINGS' NAMES, Aunts, Uncles, Cousins, Nephews, Nieces, Grandchildren, Great-Grandchildren, etc.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Joseph | | | First Joseph Middle McNally, Jr. Last McNally, Jr. | | | 2a. DATE OF DEATH
Month May Day 2 Year 1968 | | 2b. HOUR
7:40 P. M. | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
April 24, 1886 | | 6. AGE (In years
last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | |
| 7a. BIRTHPLACE (State or foreign
country) Md. | | 7b. CITIZEN OF WHAT COUNTRY?
 U. S. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) press reader | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
637 St. Anns Avenue | |
| 14. FATHER'S NAME First Joseph Middle McNally Last McNally | | | 15. MOTHER'S MAIDEN NAME First Ella Middle Hoban Last Hoban | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
219-54-3235 | | 17. INFORMANT Address
Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastric Carcinoma, presumptive. (no au-
151.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 151X
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
a) Anemia, Secondary to Ia. b) Atherosclerotic Cardiovascular Ht. Dis. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from Oct. 16 , 19 25 , to May 2 , 19 68 , that (B) (we) last saw the deceased alive on May 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Anthony J. Young, M.D. | | 22c. DATE SIGNED
5-3-68 | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
May 20 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MD. | | | | |
| 24. FUNERAL DIRECTOR
Frank D. Newell | | 25a. REC'D BY REGISTRAR
DATE MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
James Judge | | | | | | |

3

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SECRET

1500

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06745

06752

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE CO.</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>
c. LENGTH OF STAY IN 1b <u>2 DAYS</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BALTO. CO. GEN. HOSP.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
e. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAJETH</u>
d. STREET ADDRESS <u>64-18 FLOTHING AVE</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Anna</u> Middle <u>Megiel</u> Last <u>Megiel</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1968</u> | | 5. SEX <u>FEMALE</u> | | | |
| 6. COLOR OR RACE <u>CAUCASIAN</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1 JAN 1904</u> | | | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE MANAGER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FUNERAL HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>CHARLES PETROWSKI</u> | | | | | |
| 14. MOTHER'S MAIDEN NAME <u>VIOLA GUTOWSKI</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>097-07-3082</u> | | 17. INFORMANT Address <u>MAJETH, N.Y.</u>
<u>JOHN J. MEGIEL 64-18 FLOTHING AVE.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with acute coronary thrombosis</u>
(b) <u>(Case discussed with Dr. James Fredericks, medical examiner's office who asked if del sign certificate)</u>
(c) <u>4109</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1968</u> to <u>May 15, 1968</u> that (I) (we) last saw the deceased alive on <u>May 15, 1968</u> and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Paul H Royse</u> | | 22b. DATE SIGNED
<u>May 15, 1968</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>Paul H Royse</u> | | | |
| 22d. ADDRESS
<u>1403 Foley La Pikesville Md 21208</u> | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL/REMOVAL MAY 16/20, 1968</u> | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ST. JOHN'S</u> | | | |
| 23d. LOCATION (City, town or county) <u>MIDDLE VILLAGE, N.Y.</u> | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>ULLRICH FUNERAL HOME, BALTO., MD.</u>
<u>FOR JOHN J. MEGIEL, INC., MAJETH, N.Y.</u> | | 25a. REG'D BY REGISTRAR DATE <u>MAY 20 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0070A

0070B

NY
HARRIS
64-15 FLORENCE AVE

BRUNNEN CO
(KUNSTSTOFF)

Female German
GROSS HANDEL FURNE HOF
JAMES PERBANSKI
101-07-300 JAMES PERBANSKI
U.S.A. 101-07-300 JAMES PERBANSKI
MADE IN N.Y.

MADE IN N.Y.

101-07-300

MADE IN N.Y.
101-07-300

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06746

06753

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(Type or print) Agnes J. MEHRLING Mehrling | | | 2a. DATE OF DEATH
Month May Day 25 Year 1968 | | | 2b. HOUR
7:55 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1-8-16 | | 6. AGE (In years last birthday)
52 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Randallstown, Baltimore Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Belt. County Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto., | | 13c. CITY OR TOWN
Balto., | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
7014 Queen Anne Road | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Rowland Gosnell | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Agnes J. Thornton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
212-10-4282 | | 17. INFORMANT
Mr. Adrian P. Mehrling Address 7014 Queen Anne Road Balt., Md. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA Breast c metastasis
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ASHD
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 24 , 19 68 , to May 25 , 19 68 , that (I) (we) last saw the deceased alive on May 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Boon Vanasin | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 25, 68 | |
| 22d. PHYSICIAN'S NAME (Type)
BOON VANASIN | | 22e. ADDRESS
Balt. County General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Landon Park | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | |
| 24. FUNERAL DIRECTOR
Loring Byars, 8728 Liberty Road Randallstown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

08758

08758

08758

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) EDWARD | | First EDWARD | | Middle I. | | Last MILLER | | 2a. DATE OF DEATH
Month 5 Day 7 Year 68 | | | 2b. HOUR
5:00PM | |
| 3. SEX
MALE | | 4. RACE
W HITE | | 5. DATE OF BIRTH
12/5/13 | | | 6. AGE (In years lost birthday)
54 YRS. | | IF UNDER 1 YEAR
MONTHS 54 DAYS 54 | | IF UNDER 24 HRS.
HOURS 54 MIN. 54 | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VEL. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
FORMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY CHARLES | | 13c. CITY OR TOWN
BRYANS ROAD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
BOX 5EE | | | | |
| 14. FATHER'S NAME
First ANTHONY Middle J. Last MILLER | | 15. MOTHER'S MAIDEN NAME
First NELLIE Middle COBERS Last COBERS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown YES (If yes give year or dates of service) WW II | | | | | | | | |
| 16b. SOCIAL SECURITY NO.
212 05 26 72 | | 17. INFORMANT
Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
157.9
DUE TO, OR AS A CONSEQUENCE OF
ADENOCARCINOMA, PANCREAS WITH METASTASIS TO LUNGS
(b) LIVER, LYMPH NODES AND DIAPHRAGM
DUE TO, OR AS A CONSEQUENCE OF
(c) 157.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
RECENT | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
BENIGN PROSTATIC HYPERTROPHY | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (b) (this hospital) attended the deceased from 4/23/68 , 19____, to 5/7/68 , 19____, that (b) (we) last saw the deceased alive on 5/7/68 , 19____, and that in (b) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
John D. Talbert M.D. | | | | | | | | | | | 22c. DATE SIGNED
5/8/68 | |
| 22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | | | | | | | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS
MILLER FUNERAL HOME | | | 25a. REC'D BY REGISTRAR
MAY 13 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

1030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|------------------|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print)
John Miller | | | 20. DATE KNOWN OF ESTI-DEATH MATED
<input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year
May 8 1968 | | | 2b. HOUR
10:30 P.M. | | | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
10-18-1906 | 6. AGE (In years last birthday)
61 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year
May 8 1968 | | | 2d. HOUR
10:30 P.M. |
| 7a. BIRTHPLACE (State or foreign country)
Balto. Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph's | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Constoction | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
5 Fullerton Heights Ave. |
| 14. FATHER'S NAME
Nicholas Miller | | | 15. MOTHER'S MAIDEN NAME
Margaret Redel | | | ADDRESS
Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | | 16b. SOCIAL SECURITY NO.
W.W.11 217-05-9832 | | | 17. INFORMANT
Mrs. Joseph Scholten 11 Fullerton Heights | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Fractures including Neck at Base of Skull
DUE TO, OR AS A CONSEQUENCE OF
(b) Sudden
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
8147 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
8124 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
10:30 P.M. May 8 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Struck by Car while Crossing St. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Street | | 21f. LOCATION Street or R.F.D. No.
Belair Rd. opposite Towson Ave. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
5/8/68 | | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-12-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road #1236 | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

6755

6755

FOR SALE
MAY 19 1968

MAY 19 1968

FOR STATE HEALTH DEPT.

Item#13eFilm#G400 5/MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|--|--------------|----------------------------------|---|---------------------------|--------|---|--|-----------------------------------|---|--------|-----------|---|---------|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | Month | Day | Year | 2b. HOUR
3:41 | |
| Warren | | | Chester | | | Miller Jr | | | 5-5-68 | | | 19 | |
| 3. SEX
MR | 4. RACE
W | 5. DATE OF BIRTH
Nov 9 - 1914 | 6. AGE (In years
last birthday)
53 | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS | | 2c. DATE PRONOUNCED DEAD
Month | | Day | Year | 2d. HOUR
3:41 | |
| | | | | YRS. | | | | 5 | | 5 | 1968 | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | |
| Penn | | | USA | | | | | | Baltimore | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, or if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| Towson | | | St Joseph Hospital | | | STATION MANAGER | | | Bus. Co. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | |
| Md | | | Baldwin | | | Perry Hall | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 4244 Thorncliff Rd. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | | |
| Warren | | | C | | Miller | Sadie | | | | | Workinger | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| Yes | | | 216-07-1446 | | | James W. Miller | | | 837 N. Lexington St. Annapolis | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>Sudden</u>
<u>410.0</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hypertensive Cardio-renal</u> <u>24 yes</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Vascular Disease</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>4201</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | EXAMINER'S
NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED | | | | |
| Charles F. O'Donnell | | | Charles F. O'Donnell, M.D. | | | | | | 5/5/68 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) | (State) |
| Burial | | | May 9 - 1968 | | | Baldwin National | | | Baldwin | | | Md | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| C. F. Evans & Son | | | 8802 HARTFORD RD | | | MAY 7 1968 | | | [Signature] | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05150

05150

05150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Sidney Davis MILNOR | | | | | | 2a. DATE OF DEATH
Month Day Year
May 10, 1968 | | | 2b. HOUR
12:45 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
August 28, 1902 | | | 6. AGE (In years last birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Schoolteacher-Ret. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Public School | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Towson, Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
909 Dulaney Valley Court | | | |
| 14. FATHER'S NAME First Middle Last
Malcolm T. Milnor | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ada Champion | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Jean Milnor, 909 Dulaney Valley Ct., Towson, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive peritoneum hemorrhage
441.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) rupture of aortic aneurysm.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
022X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 5/9/ 19 68 , to 5/10/ 19 68 , that (X) (we) last saw the deceased alive on 5/10/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
William | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 10, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 14, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Wildwood Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Williamsport, Pennsylvania | | | | | |
| 24. FUNERAL DIRECTOR
John Burns' Sons, Towson, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
John Judge | | | | |

MEDICAL CERTIFICATION

06750

DEPARTMENT OF STATE

06751

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[The remainder of the teletype message is illegible due to extreme fading and bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06751 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06758 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Item 13e Film G401 6/5/68 km | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) James L. Montgomery | | | | | First Middle Last | | | | | 2a. DATE OF DEATH
Month May Day 29 Year 68 | | | | | 2b. HOUR
1A | | | | | | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
W | | | | | 5. DATE OF BIRTH
Aug. 17, 1875 | | | | | 6. AGE (In years last birthday)
92 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Balto. | | | | | Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Ridgeway Nursing Home | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Florist | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | | 13b. COUNTY
Balto. | | | | | 13c. CITY OR TOWN
Balto. | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
101 Ingleside Avenue | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
219-22-3898 | | | | | 17. INFORMANT
Mrs. Nettie Joyce, Balto., Md. 21228 | | | | | Address
101 Ingleside Avenue | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary atherosclerosis
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 year , 19 68 , to 29 May , 19 68 , that (I) (we) last saw the deceased alive on 29 May , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
William Goodman, M.D. DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED
29 May 68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. William Goodman | | | | | | | | | | | | | | | 22e. ADDRESS
1334 Sulphur Spring Rd., Balto., Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
5-31-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR 4101 Edmondson Avenue ADDRESS
Witake Funeral Directors, Balto., Md. 21229 | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Sylvia | | First | | Middle | | Last | | 2a. DATE OF DEATH
May 12, 1968 | | 2b. HOUR
10:05 P. | |
| 3. SEX
female | | 4. RACE
Negro | | 5. DATE OF BIRTH
Sept. 30, 1934 | | 6. AGE (In years last birthday)
33 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
237 N. Culver Street | | | |
| 14. FATHER'S NAME
James Wiggins | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME
Esther Carroll | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, organism undt. 2 days.
485X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6 , 19 68 , to May 12 , 19 68 , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on May 12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Anthony J. Young</i> DEGREE
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | | | | | | | 22c. DATE SIGNED
5-13-68 | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Charles A. Rice | | | | ADDRESS
661 W. Barre St. | | 25a. REC'D BY REGISTRAR
DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

MEDICAL CERTIFICATION

2250

city, 1992

1914.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06753

CERTIFICATE OF DEATH

06760

| | | | | | | | | | |
|--|--|--|------------------------|---|--|---|--|--|-----------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First
Anna | Middle
Marie | Last
MORGAN | 2a. DATE OF DEATH
Month May Day 3 Year 1968 | | 2b. HOUR
11:25 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
June 4, 1922 | | 6. AGE (In years lost birthday)
45 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
At Home | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2419 Harwood Rd. | |
| 14. FATHER'S NAME First
Thomas | | Middle
J. | | Last
Morgan | | 15. MOTHER'S MAIDEN NAME First
Mary A. | | Middle
Gately | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Family records | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized peritonitis
562.1
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 572.1
(b) Perforated diverticulum - descending colon
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Congestive heart failure; Generalized neoplasia. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County |
| 22a. I certify that NO (this hospital) attended the deceased from 4/23/ 19 68 , to 5/3/ 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/3/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 3, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town)
Balto | | (County) (State)
Md. | |
| 24. FUNERAL DIRECTOR
C.F. EVANS & SON | | | | ADDRESS
8802 Harford Rd. | | 25a. REC'D BY REGISTRAR
DATE MAY 6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

00700

00700

Report of the Committee

on the activities of the

Committee on the activities of the

Committee on the activities of the

Committee on the activities of the

Committee on the activities of the

Committee on the activities of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Harriot Louise Morison | | 2a. DATE OF DEATH
Month May Day 21 , Year 1968 | | 2b. HOUR
11:35 p. | |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
Feb. 3, 1886 | 6. AGE (In years last birthday)
82 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | IF UNDER 24 HRS.
HOURS _____ MIN. _____ |
| 7a. BIRTHPLACE (State or foreign country)
N. Y. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Catonsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
32 Delroy Avenue | |
| 14. FATHER'S NAME First Middle Last
Edward Booth | | 15. MOTHER'S MAIDEN NAME First Middle Last
Gertrude Wardell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-54-0869J | 17. INFORMANT Address
RECORDS: Spring Grove State Hospital | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Right lower lobe pneumonia
481X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
490X Uremia - Diabetes mellitus | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year _____
P.M. _____ 19 _____ | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work _____ at work _____ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 5, 1967 , to May 21, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Diomidis Pirovolidis, M.D. DEGREE _____ | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
5-22-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE
May 23, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Crematory | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
Sterling Funeral Estate
796 Edmondson Ave.
Catonsville, Md. 21228 | | 25a. REC'D BY REGISTRAR
DATE MAY 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>06755</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06762</div> | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---------------------------|--|--|-------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
MARY | | | Middle
KELLNER | | | Last
NAIMAN | | | 2a. DATE OF DEATH
Month
May | | | Day
5 | | | Year
1968 | | | 2b. HOUR
4 a m | | |
| 3. SEX
Female | | | 4. RACE
Cauc. | | | 5. DATE OF BIRTH
1-15-1897 | | | 6. AGE (In years last birthday)
71 YRS. | | | IF UNDER 1 YEAR
MONTHS | | | OAYS | | | IF UNDER 24 HRS.
HOURS | | | MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore County Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Balt. med. Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
6246 Woodcrest Ave. | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Julius | | | Middle
Kessler | | | Last
IDA | | | 15. MOTHER'S MAIDEN NAME
First
IDA | | | Middle
Slesinger | | | Last
Slesinger | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
214-22-4391 | | | 17. INFORMANT
MRS. DORIS NAIMAN | | | Address
6246 WOODCREST AVENUE | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>uremia</u>
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>acute renal failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>metabolic ex.</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
a few days
a few days
4 months | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1992 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3/18/68
4/15/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Radiation necrosis | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> , 19 <u>68</u> , to <u>5-5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-5</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Agustin Collado</u> | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5-5-68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Agustin Collado, M.D. | | | 22e. ADDRESS
Greater Balt Med Center | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
5-6-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
POSVOHLER FRIENDLY SOCIETY | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

Belmore, Ill.

821-10000-10000

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Kessler

17C-42-415

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Case

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div>06756</div> <div>Item 2a, Film # G400 5/13/68 km</div> <div>06763</div> | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|---|---|--|
| <div>MD</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Emory Monroe Naylor</i> | | | | | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>6</i> Year <i>1968</i> | | | 2b. HOUR
<i>12:30</i> M | | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
<i>Dec 10. 1879</i> | | | 6. AGE (In years lost birthday)
<i>88</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> |
| 7a. BIRTHPLACE (State or foreign country)
<i>Balto. Co. Md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore County Md.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Garrison</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Fox Leigh</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Farmer</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Black Decker</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Towson</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>617 Debaugh Avenue 21204</i> | | |
| 14. FATHER'S NAME First Middle Last
<i>George Washington Naylor</i> | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Elizabeth Cole</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, at unknown) (If yes give war or dates of service)
<i>NO</i> | | | 16b. SOCIAL SECURITY NO.
<i>216-10-3521</i> | | 17. INFORMANT Address
<i>Mrs Marie Horton 617 Dabaugh Avenue (4)</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
<i>4409</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Generalized arteriosclerosis -</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5-4-68</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4500 Chronic Brain Syndrome</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <i>10-13</i> , 19 <i>66</i> , to <i>5-5</i> , 19 <i>68</i> , that (X) (we) lost
saw the deceased alive on <i>5-5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Rafael Perez-Mera MD</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-6-68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>RAPHAEL PEREZ-MERA</i> | | | | | | 22e. ADDRESS
<i>7306 LIBERTY Rd</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>5-8-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Trinity Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Long Green Baltimore Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Lassahn Funeral Home 7401 Belair Road 21236</i> | | | | | | 25a. RECORD BY REGISTRAR
<i>MAY 8 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Judge</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Felix | | First RAY | | Middle NEALS | | Last | | 2a. DATE OF DEATH
Month MAY Day 15 Year 1968 | | | 2b. HOUR
6:35 A M | |
| 3. SEX
F | | 4. RACE
Negro | | 5. DATE OF BIRTH
2-7-1907 | | | 6. AGE (In years last birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS 6 DAYS 15 | | IF UNDER 24 HRS.
HOURS 6 MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
FLORIDA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTO. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. Co. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater-BALTO. Medical Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
EXPOSIVES- Oper. | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | 13b. COUNTY — | | 13c. CITY OR TOWN — | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1800 ELLAMONT ST | | | |
| 14. FATHER'S NAME First Julius Middle — Last NEALS | | | 15. MOTHER'S MAIDEN NAME First HATTIE Middle CORA Last NEALS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | | 16b. SOCIAL SECURITY NO.
266-26-8339 | | 17. INFORMANT Address E/1515 NEALS 1800 ELLAMONT ST | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac-pulmonary insufficiency
150X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) metastatic Ca of the Esophagus and Stomach
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
150X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from 5-3 , 19 68 , to 5-15 , 19 68 , that (H) (we) last saw the deceased alive on 5-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
ER Soudyn | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-15-68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Edward R. Soudyn | | 22e. ADDRESS
G.B.M.C Charles Street Balto | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Buried | | 23b. DATE
5/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY
MD HUBURN | | 23d. LOCATION (City or Town) (County) (State)
Baltimore MD | | | | | | |
| 24. FUNERAL DIRECTOR
Marion P. King | | ADDRESS
638 D Gilman | | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

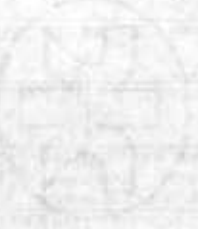
MEDICAL CERTIFICATION

05764

05757

Wetzel & Co. of the Empire State
Cash & Carry

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RECEIVED
JAN 10 1908
NEW YORK

RECEIVED
JAN 10 1908
NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|
| 1. DECEASED-NAME (Type or print) <i>Eleanor Laura</i> | | First <i>Needham</i> | | Last | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>27</i> Year <i>68</i> | | | 2b. HOUR
<i>7:30 A M</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>CAU.</i> | | 5. DATE OF BIRTH
<i>11/3/1890</i> | | 6. AGE (In years last birthday)
<i>77</i> YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Baltimore Co. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore, Md.</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Greater Baltimore Medical Center</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Md</i> | | 13c. CITY OR TOWN
<i>Lutherville</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>W. Seminary Ave P.O. Box 223</i> | | |
| 14. FATHER'S NAME
First <i>James</i> Middle <i>P</i> Last <i>Reese</i> | | 15. MOTHER'S MAIDEN NAME
First <i>LOUISE L.</i> Middle <i>Leisenring</i> Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Patient's Chart</i> Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Pulmonary Embolism</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Acute Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hour</i>
<i>60 hours</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>4201</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-24</i> , 19 <i>68</i> , to <i>5-27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Derek A Bruce</i> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>5/27/68</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>DEREK A. BRUCE</i> | | 22e. ADDRESS
<i>G. B. N.C.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>5/29/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Dulaney Valley Memorial</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Cockeysville Md.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>John Burns Sons</i> | | ADDRESS
<i>Lawsol</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 29 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. ...</i> | | | | |

00786

CHAIRMAN OF BOARD

00786

THE BOARD OF DIRECTORS OF THE
UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250
OFFICE OF THE CHIEF OF BUREAU
OF AGRICULTURAL MECHANIZATION
WASHINGTON, D. C. 20250

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06759

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06766

| | | | | | | | | | | | |
|--|---------|------------------------------|---|---|--|---|--|---|---|----------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2. DATE KNOWN OF DEATH | | | | 2b. HOUR | |
| Thomas P. Neuberger | | | | | | Month Day Year
5-4-68 19 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| Male | W | Oct. 1, 1916 | 51 YRS. | | | Month Day Year
5 4 19 68 | | | | 11:15M | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Balto. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 1414 Woodcliff Avenue | | | Lawyer | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Balto. | | Balto. | | | 1414 Woodcliff Avenue | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Andrew Neuberger | | | Margaret Neuberger | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| No | | | 215-03-3374 | | 1414 Woodcliff Avenue
Mrs. Thomas P. Neuberger, Balto., Md. 21228 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>4201</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| EXAMINER'S NAME (Type) Clarence E. McWilliams, M.D. | | | ADDRESS (Street, city, town, or county) <u>11904 Lantana Rd. Baltimore, Md.</u> | | | 22b. DATE SIGNED <u>May 6, 1968</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 5-8-68 | | Lorraine Park Cemetery | | | Balto., Md. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Witzke Funeral Directors, Balto., Md. 21229 | | | 4101 Edmondson Avenue | | | MAY 7 1968 | | | Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

Stanley 06760

06767

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) <i>Stanley</i> First Middle Last <i>Ohab</i> | | | 2a. DATE OF DEATH
5 Month 29 Day 68 Year | | 2b. HOUR
8:35 ^A M |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
9-25-1888 | | 6. AGE (In years last birthday)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>Poland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Towson, Md</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Chesapeake Manor N.H.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>retired farmer</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Farm</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | 13b. COUNTY
<i>Balto.</i> | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
<i>61 A. Sewersky Court</i> | |
| 14. FATHER'S NAME First Middle Last
<i>George Ohab</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Julia Renot</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) <i>none</i> | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address
<i>Family records</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CANCER OF THE PROSTATE</i>
<i>185X</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>177X</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 15, 1968</i> to <i>May 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Luis J. Evans M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) <i>Luis J. Evans, M.D.</i> | | | | 22e. ADDRESS
<i>1701 Meridiano Dr. Balto. Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| <i>Burial-transit</i> | <i>6/1/68</i> | <i>All Sts. Polish National</i> | | <i>Rome New York</i> | |
| 24. FUNERAL DIRECTOR
<i>John Burns Sons</i> | | ADDRESS
<i>Towson</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 31 1968</i> | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

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RECEIPT OF PAID

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Dennis D. O'Leary</i> | | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>3</i> Year <i>1968</i> | | | 2b. HOUR <i>8 P.M.</i> | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>Oct. 9, 1873</i> | | 6. AGE (In years last birthday) <i>94</i> YRS. | |
| 7b. BIRTHPLACE (State or foreign country) <i>Cambridge, Mass.</i> | | 7c. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore County Md.</i> | |
| 10. CITY OR TOWN OF DEATH <i>Catonsville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Real Estate Broker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Self-Emp.</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER <i>1914 Old Frederick Rd.</i> | | 14. FATHER'S NAME First <i>Dennis</i> Middle <i>O'Leary</i> Last <i></i> | | 15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Burke</i> Last <i></i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. <i>212-01-5316</i> | | 17. INFORMANT <i>Mrs. Ann P. Hoffman</i> | | Address <i>1914 Old Frederick</i> | | Road <i></i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i>
<i>4129</i> DUE TO, OR AS A CONSEQUENCE OF
(b) <i>ASCVD</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>
<i>20 yrs</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>4221 Right lobar pneumonia</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1 Jan</i> , 19 <i>63</i> , to <i>3 May</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3 May</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>James E. Rowe</i> | | 22c. DATE SIGNED <i>5/3/68</i> | | 22d. PHYSICIAN'S NAME (Type) <i>JAMES E. ROWE</i> | | 22e. ADDRESS <i>CATONSVILLE, MD 21228</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>5/7/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery - Baltimore, Maryland</i> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <i>Sterling Funeral Estate of Catonsville</i> | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <i>MAY 7 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

03730

DEPARTMENT OF STATE

03730



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 06762 MARYLAND STATE DEPARTMENT OF HEALTH 06769 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print)
EDWARD A. ONHEISER | | | | | | 2a. DATE OF DEATH
Month 5 Day 15 Year 68 | | | 2b. HOUR
2:30P M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
9/26/16 | | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ELECTRICIAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
AIRCRAFT | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | 13b. COUNTY — ✓ | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1724 Eastern Avenue | |
| 14. FATHER'S NAME First Peter Middle Onheiser Last Onheiser | | | | 15. MOTHER'S MAIDEN NAME First Catherine Middle Miller Last Miller | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or, unknown <input checked="" type="checkbox"/> (If yes give war and dates of service)
PL 28 | | | | 16b. SOCIAL SECURITY NO.
215 05 43 25 | | 17. INFORMANT Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 5 Day 14 Year 68
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. 5/14/68 | | City or Town 5/15/68 | | County | | State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 5/14/68 , 19 68 , to 5/15/68 , 19 68 , that (X) (we) last saw the deceased alive on 5/15/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John D. Talbert, M.D. | | | | | | DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/16/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO NATL. | | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR
T. FISHER | | 25. ADDRESS
FISHER FUNERAL HOME | | | | 25a. RECEIVED BY REGISTRAR
MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |
| 1730 EASTERN AVE. BALTIMORE, MD. 21231 | | | | | | | | | | | |

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06762

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06770

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
MARGARET C. O'SULLIVAN | | | 2a. DATE OF DEATH Month Day Year
5 30 68 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
9/28/98 | | 6. AGE (In years last birthday) YRS.
69 | |
| 7a. BIRTHPLACE (State or foreign country)
Scotland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
15 Nightingale Way | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
15 Nightingale Way | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
James O'Roddy | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret McDade | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
108-20-9313 | | 17. INFORMANT Address
Brian M. O'Sullivan-15 Nightingale Way | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Uræmia
180X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Recurrent Carcinoma of prostate
DUE TO, OR AS A CONSEQUENCE OF
(c) Primary Carcinoma of | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
171X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-24, 1964 , to 5-30, 1968 , that (I) (we) last saw the deceased alive on 4-20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Wm. A. Rogers DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
6/1/68 | |
| 22d. PHYSICIAN'S NAME (Type)
William A. Rogers, M.D. | | | | 22e. ADDRESS
815 Eastern Blvd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS
Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Baltimore, Maryland 21214 | | | | 25a. REC'D BY REGISTRAR
JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div>06766</div> <div> <div>8</div> <div>1</div> </div> <div> <div>06771</div> <div>1</div> </div> | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) CHARLES DAVID OSWINKLE | | | | | | 2a. DATE OF DEATH
Month May Day 2 Year 1968 | | | 2b. HOUR
7:35 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
September 18, 1890 | | | 6. AGE (In years last birthday) 77 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4410 Raspe Ave., 21206 | | |
| 14. FATHER'S NAME First John Middle Oswinkle Last Oswinkle | | | | 15. MOTHER'S MAIDEN NAME First Alice Middle Keller Last Keller | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes | | | 16b. SOCIAL SECURITY NO.
212-34-8950 | | 17. INFORMANT Address
Rose Marie Oswinkle-4410 Raspe Ave., 21206 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive acute myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary artery thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from April 26, 1968 , to May 2, 1968 , that (X) (we) last saw the deceased alive on May 2, 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Reynaldo Orjuela-Gomez, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
May 3, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-6-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06765

06772

| | | | | | | | |
|---|--|--|--------|--|--|---|---|
| 1. DECEASED-NAME (Type or print) BARNEY | | First | Middle | Last | 2a. DATE OF DEATH
Month MAY Day 25 Year 1968 | | 2b. HOUR
6:34 PM |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 5, 1908 | | 6. AGE (In years last birthday)
59 YRS. | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
(Civings) Mill Rd | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
Randalltown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
BALTIMORE COUNTY HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
B & O R.R. Welder | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY
RANDALLTOWN | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Barney Middle - Last Civings Sr | | 15. MOTHER'S MAIDEN NAME First Evelyn Middle - Last Glatim | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
705-07-6451 | | 17. INFORMANT
Mr. John F. Owings Address 4228 Mill Road Balto, Md. 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE MYOCARDIAL INFARCTION
441.0
DUE TO, OR AS A CONSEQUENCE OF
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
451X
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HRS.
YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
HYPERTENSION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 25, 1968 , to MAY 25, 1968 , that (I) (we) last saw the deceased alive on MAY 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Rene P. de los Santos DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
5-25-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Md | |
| 24. FUNERAL DIRECTOR
Looring Byers - 5728 Liberty Road - Randalltown, Md | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
James Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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| | | | | | | | | |
|--|---------|--|------------------|---|-------------------------------------|---|--------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
a. m. | |
| Rosa | | | | Patrick | May 2, 1968 | | 8:10 a. | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| female | Negro | | Aug. 21, 1883 | | 84 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| N. C. | | U. S. | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Catonsville | | SPRING GROVE STATE HOSP. | | housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | | Balto. | | | | 316 N. Edgewood St. |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | |
| Unknown | | | | Lou Calman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | 217-54-2689 | | Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
<u>4120</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertensive cardiovascular disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>443X</u>
<u>Asthma</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>April 30, 1968</u> , to <u>May 2, 1968</u> , that (X) (we) last saw the deceased alive on <u>May 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Narciso Carmona M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>5-2-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Narciso Carmona, M.D.</u> | | | | 22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>
<u>Baltimore, Maryland 21228</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| <u>Burial</u> | | <u>5/6/68</u> | | <u>Washington Branch</u> | | <u>BERTIE Co. N. C.</u> | | |
| 24. FUNERAL DIRECTOR <u>Mas Gore P. Jones</u> ADDRESS <u>638 N. G. 1600</u> | | | | 25a. REC'D BY REGISTRAR <u>DATE MAY 3 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | |
|--|--|--|---|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) William B. Pearce | | | 2a. DATE OF DEATH
Month 5 Day 12 Year 68 | | | 2b. HOUR
10:55p M | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
Nov. 9, 1879 | | 6. AGE (In years last birthday)
88 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
S. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> sep DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
house painter | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
94 Mosher Street | |
| 14. FATHER'S NAME First Middle Last
Oliver B. Pearce | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna Melton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown | | 16b. SOCIAL SECURITY NO.
215-03-4062 | | 17. INFORMANT Address
Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
486X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
493X | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 27, 19 41 , to 5/12 , 19 68 , that (I) (we) last saw the deceased alive on May 12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Dennis D. Agallianos MD | | | | 22c. DATE SIGNED
5/12/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) DENNIS D. AGALLIANOS | | | | 22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY
PENINSULA MEMORIAL PK. | | 23d. LOCATION (City or Town) (County) (State)
New Port News Va | | |
| 24. FUNERAL DIRECTOR
Weymouth F. H. New Port News Va
E.S. McNeil Balto Md | | | | 25a. REC'D BY REGISTRAR
DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

MEDICAL CERTIFICATION

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SPRINTING OF BATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Nona Francis PETERS | | | 2a. DATE OF DEATH
Month Day Year
May 13, 1968 | | 2b. HOUR
9:05AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
June 28, 1894 | | 6. AGE (In years last birthday)
73 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore, Md. | | |
| 10. CITY OR TOWN OF DEATH
Towson | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE* (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Timonium | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
112 Springdale Dr. | |
| 14. FATHER'S NAME First Middle Last
Newton Wassthler | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)
None | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address
Family records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
(b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary arteriosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of pancreas with metastasis | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/5/ , 19 68 , to 5/13/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/13/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Icilliani | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED
May 13, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
May 17, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
May's Chapel Cemetery | 23d. LOCATION (City or Town) (County) (State)
Timonium, Md. | | |
| 24. FUNERAL DIRECTOR
John Burns' Sons, Towson, Md. | | | 25. REC'D BY REGISTRAR
DATE MAY 17 1968 | | |
| | | | 26. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Helen | | | First K. Middle PFEIFFER Last | | | 2a. DATE OF DEATH
Month May Day 2 Year 1968 | | 2b. HOUR 11:18 a.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH
January 22, 1921 | | 6. AGE (In years lost birthday) 47 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore, Md. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 3512 Dunhaven Rd. | |
| 14. FATHER'S NAME First Joseph Middle Kelly Last | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Oberle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 212-18-8640 | | 17. INFORMANT (Husband) Mr. George Pfeiffer, 3512 Dunhaven Rd. | | Address Dundalk, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of right lung with metastasis
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
163X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/26/ , 19 68 , to 5/2/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/2/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ramon P. Lopez | | DEGREE M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED May 2, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M.D. | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR MAY 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|------------------------------------|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>Estelle F. Phillips</u> | | | | | | 2a. DATE OF DEATH
Month <u>5</u> Day <u>28</u> Year <u>68</u> | | | 2b. HOUR
<u>11:45 PM</u> | | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>W</u> | | 5. DATE OF BIRTH
<u>8-16-89</u> | | | 6. AGE (In years lost birthday)
<u>78</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS.
HOURS <u> </u> MIN. <u> </u> |
| 7a. BIRTHPLACE (State or foreign country)
<u>Delaware</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Baltimore Co.</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>GARRISON MD.</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>FOXHEIGH HOME</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>HOUSEWIFE</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>DEL.</u> | | | 13b. COUNTY
<u>Sussex</u> | | 13c. CITY OR TOWN
<u>LAUREL</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>12 S. SAFFORD HIGHWAY RD 23</u> | | |
| 14. FATHER'S NAME First Middle Last
<u>PARRON T. SHORT</u> | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>CORDelia F. SHORT</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <u>NO</u> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>CORDelia P. Gilbert</u> | | | Address <u>Roundridge Rd FINEMOUNT MD</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Arteriosclerosis</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u> </u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>331X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>
P.M. <u> </u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-24</u> , 19 <u>67</u> , to <u>5-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-26</u> , 19 <u>68</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>David J. Miller</u> | | | | | | DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>5-29-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>David J. Miller</u> | | | | | | 22e. ADDRESS
<u>Owings Mills, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE
<u>5-31-68</u> | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ODD Fellows Cem.</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Laurel Sussex Del</u> | | |
| 24. FUNERAL DIRECTOR
<u>Robert S. Barranco</u> | | | | | | ADDRESS
<u>Severna Park, Md.</u> | | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 3 1968</u> | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
|--|--|--|--|---|-------------------|---|---|--|-----------------------------------|--|--|
| Charles | | | | | | Plassil | May | 9 | 5:45 | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| male | | white | | Nov. 30, 1885 | | 82 YRS. | | MONTHS | DAYS | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Md. | | U. S. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | merchant seaman | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | | | Baltimore | | | | 4706 Park Heights Avenue | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| Martin | | | | Plassil | | Anna | | Plassil | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| | | | | | | Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| ASCD | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from March 20, 19 22, to May 9, 19 68, that (I) (we) lost saw the deceased alive on May 9, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| A. B. Hooton, M.D. | | | | | | | | | | 5-9-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| A. B. Hooton, M.D. | | | | | | SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 5-10-68 | | National Bohemian Cemetery | | Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229 | | | | | | DATE MAY 13 1968 | | J. Charles Jones | | | |

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OFFICE OF THE DIRECTOR

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Nov. 10, 1950

Nov. 10, 1950

Nov. 10, 1950

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Director, Federal Bureau of Investigation

Re: [illegible]

Re: [illegible]

Re: [illegible]

Very truly yours,

Very truly yours,

[illegible signature]

[illegible signature]

B-270



CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|---------|--|--|--|--|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| HELEN | | | A. POETZEL | | | MAY Month 29 Day 1968 Year | | | 5:20AM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| FEMALE | WHITE | | OCTOBER 21, 1908 | | | 59 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| MARYLAND | | | U.S.A. | | | 9. COUNTY OF DEATH
BALTIMORE, Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TOWSON | | | ST. JOSEPH HOSPITAL | | | HOMEMAKER | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
JOHN RETTMAN | | | First Middle Last
KATHERINE KEUMET | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| NO | | | NONE | | | Joseph C. Poetzel : 802 S. Fagley St. #24 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u>
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u>
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Septicemia due to Gram-negative bacteria.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that: (X) (this hospital) attended the deceased from <u>MAY 14</u> , 19 <u>68</u> , to <u>MAY 29</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>MAY 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Reynaldo Orjuela-Gomez, M.D. | | | May 29, 1968 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Reynaldo Orjuela-Gomez, M.D. | | | 7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | 6-1-68 | | | Sacred Heart Cemetery | | | 7401 German Hill Rd., Md |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Charles S. Seiler | | | DATE JUN 3 1968 | | | Charles Seiler | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
30M. REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
Matilda | | | First
Matilda | | | Middle
NMN | | | Last
PONS | | | 2a. DATE OF DEATH
5 Month 20 Day 68 Year | | | 2b. HOUR
3:15 a.m. | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
12/18/1897 | | | 6. AGE (In years last birthday)
70 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Balto. Medical Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
At home | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Parkville | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
3001 Lavender ave | | | | | |
| 14. FATHER'S NAME First
John Komenda | | | Middle
John Komenda | | | Last
John Komenda | | | 15. MOTHER'S MAIDEN NAME First
Barbara Melachar | | | Middle
Barbara Melachar | | | Last
Barbara Melachar | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | 17. INFORMANT
Hospital records | | | Address
Hospital records | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Primary carcinoma of liver
1550
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1550 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/8 , 19 68 , to 5/20 , 19 68 , that (I) (we) last saw the deceased alive on 5/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John E. Adams | | | DEGREE
John E. Adams, M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
5/20/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | | | 22e. ADDRESS
6701 N. Charles Street | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
5/24/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
Chas. F. Evans + Son | | | ADDRESS
8802 Hanford Rd | | | 25a. REC'D BY REGISTRAR
DATE MAY 24 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

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[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06774

CERTIFICATE OF DEATH

06781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---|---|---|--|--|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mercy Villa Nursing Home | | | | d. STREET ADDRESS
3501 St. Paul St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Marion Middle Price Last Price | | | | 4. DATE OF DEATH
Month May Day 21 Year 1968 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 1895
May 4, 1894 | | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert O'Brien | | | | 14. MOTHER'S MAIDEN NAME
Lillie Burkart | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year and dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
703-07-9569 | | 17. INFORMANT Address
Sister M. Carlotta, R.S.M., 6400 Bellona Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized & Cerebral Arteriosclerosis</u>
DUE TO
(b) <u>437.9</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
334x | | | | | | 19. WAS AUTOPSY PERFORMED?
NO | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>1968</u> that (I) (we) last saw the deceased alive on <u>May 17, 1968</u> , and that death occurred at <u>7:5 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Walter B. Buck</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5/22/68</u> | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Walter Buck | | | | 22d. ADDRESS
14 E. Eager St. Balto. Md. | | | |
| 23a. BURIAL, CREMATION, REBURY (Specify)
Burial | | 23b. DATE THEREOF
5-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS 21204 | | | | 25a. REC'D BY REGISTRAR MAE 27 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| WM.E. Johnson, 8521 Loch Raven Blvd. Balto. Md. | | | | | | | |

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1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>06773</div> <div>06782</div> <div> <div>2</div> <div>1</div> </div> <div> <div>58</div> <div>03</div> <div>1</div> </div> | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---------------------------|--|--|
| <div> <div>06773</div> <div>06782</div> </div> <div> <div>2</div> <div>1</div> </div> <div> <div>58</div> <div>03</div> <div>1</div> </div> | | | | | | | | | | | | | | | | | | | | | | | |
| <div> <div>06773</div> <div>06782</div> </div> <div> <div>2</div> <div>1</div> </div> <div> <div>58</div> <div>03</div> <div>1</div> </div> | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Ida | | | Middle
PRIEBER | | | Last
PRIEBER | | | 2a. DATE OF DEATH
Month
May | | | Day
8 | | | Year
1968 | | | 2b. HOUR
8:25AM | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
May 28, 1878 | | | 6. AGE (In years last birthday)
89 YRS. | | | IF UNDER 1 YEAR
MONTHS
90 | | | IF UNDER 24 HRS.
HOURS
90 | | | MIN.
90 | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | | 7b. CITIZEN OF WHAT COUNTRY?
unknown | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore, | | | | | | | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Balto. | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
2608 Matthews Drive | | | | | | | | | | | |
| 14. FATHER'S NAME First
CARL | | | Middle
LIETZAU | | | Last
LIETZAU | | | 15. MOTHER'S MAIDEN NAME First
WILLAMENA | | | Middle
ENGLER | | | Last
ENGLER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown | | | 16b. SOCIAL SECURITY NO.
--- | | | 17. INFORMANT
Son. | | | Address
Same | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Intestinal infarction | | | | | | | | | | | | | | | | | | | | | | | |
| 444.2 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | |
| 5702 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
May 7, 1968 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Possible mesenteric thrombosis | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
--- P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 5/7/ , 19 68 , to 5/8/ , 19 68 , that (X) (we) last saw the deceased alive on 5/8/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Reynaldo Orjuela-Gomez, M.D. | | | | | | | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED
May 8, 1968 | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | | | | | | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
5/11/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
IMMANUEL Cem. | | | 23d. LOCATION (City or Town) (County) (State)
BALTO | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
P. A. HEEMANN | | | ADDRESS
6067 HARFORD | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06776

06783

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) ^{First} XXXX ^{Middle} Ferdinand ^{Last} SALVATORE PUCCI | | | 2a. DATE OF DEATH ^{Month} MAY ^{Day} 2 ^{Year} 1968 | | 2b. HOUR 4:15P ^M |
| 3. SEX MALE | | 4. RACE WHITE | 5. DATE OF BIRTH 3/22/23 | | 6. AGE (In years last birthday) 45 ^{YRS.} |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE COUNTY, ^{MD.} |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BRICKLAYER | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 4517 CLAREWAY, |
| 14. FATHER'S NAME ^{First} PETER ^{Middle} PUCCI ^{Last} | | | 15. MOTHER'S MAIDEN NAME ^{First} ANNA ^{Middle} BISCOTTI ^{Last} | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? ^{Yes (no or unknown)} YES ^(If yes give war or dates of service) WW II | | 16b. SOCIAL SECURITY NO. 215 16 96 41 | | 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. ^{Address} | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY ^{HOUR A.M.} ^{Month Day Year} 19 ^{P.M.} | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED ^{While} <input type="checkbox"/> ^{Not while} <input type="checkbox"/> ^{at work} <input type="checkbox"/> ^{at work} <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION ^{Street or R.F.D. No.} ^{City or Town} ^{County} ^{State} | |
| 22a. I certify that the (this hospital) attended the deceased from 5/1/68 , 19__, to 5/2/68 , 19__, that it (we) lost saw the deceased alive on 5/2/68 , 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Ahmed Kutty MD ^{DEGREE} ^{ATTENDING PHYS.} <input type="checkbox"/> ^{MED. DIRECTOR} <input type="checkbox"/> ^{STAFF PHYS.} <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 5/3/68 |
| 22d. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M.D. | | | 22e. ADDRESS VAH FORT HOWARD, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 5/6/68 | 23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR Joseph N. Zannino | | ADDRESS JOSEPH N. ZANNINO FUNERAL HOME | | 25a. REC'D BY REGISTRAR DATE MAY 8 1968 | |
| | | 257 S. Conkling St. Baltimore, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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James K. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|---|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Loretta A. Queen | | | | | | 5 Month 6 Day 68 Year | | 4:45 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| F | | W | | 7/5/1886 | | 81 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Va. | | USA | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Towson | | | Stella Maris Hospice | | | Housewife | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | Baltimore | | YES | | 3501 St. Paul St. Balto. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Cornelius Wholey | | | Hannah Collins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 220-W-5580 | | Hospice records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) ASCA | | | | | | | | | YRS |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | YRS |
| (b) Compot. Injurer | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Pulmonary Embolism | | | | | | | | | 1 WEEK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/5/66, 19__, to 5/6/68, 19__, that (I) (we) last saw the deceased alive on 5/3/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | |
| Robert J. Mahon, MD | | | | | | | | 5/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| Robert J. Mahon, MD | | | | 204 E. Joppa, Rd. Towson | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-8-68 | | New Cathedral | | Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| H.W. Jenkins & Sons Co. 4905 York Rd. Balto. | | | | MAY 8 1968 | | Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

VR A-1 (10)
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|-----------------|--|---|---|---|--|--|--------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First
MARY | Middle
AGNES | Last
RACKENSBERGER | 2a. DATE OF DEATH
Month 15 Day 1968 | | 2b. HOUR
11:55 P | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUGUST 27, 1927 | | 6. AGE (In years
last birthday)
40 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission)
STATE MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1801 ABERDEEN RD. #21234 | | | |
| 14. FATHER'S NAME
First Middle Last
Jacob J. Rackensperger | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Agnes Schaffer | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-01-8560C | | 17. INFORMANT
Mrs. Agnes Rackensperger | | Address
Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Granulomatous peri-carditis
519.2 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) Multiple granulomas of both lungs and lymph nodes.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
525X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from MAY 3, 19 68, to MAY 15, 19 68, that (X) (we) lost
saw the deceased alive on MAY 15, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence F. Misanik, M.D. | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 16, 1968 | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Lawrence F. Misanik, M.D. | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
burial | | 23b. DATE
5/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Mitchell-Wiedefeld Home 6500 York Rd.
Balto., Md. 21212 | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06778 CERTIFICATE OF DEATH 06786

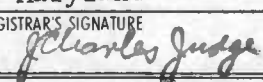
| | | | | | |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1d | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>226 Linden Avenue</u> | | | d. STREET ADDRESS
<u>608 Highland Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Corrinne</u> Middle <u>Fleury</u> Last <u>Raphel</u> | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>26</u> Year <u>1968</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov 26, 1884</u> | 9. AGE (In years last birthday)
<u>83</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>Paul Aimee Fleury</u> | | |
| 14. MOTHER'S MAIEN NAME
<u>Lydia Jenkins</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | |
| 16. SOCIAL SECURITY NO.
<u>none</u> | | | 17. INFORMANT
<u>Family records</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
<u>4129</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u>
DUE TO (c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>4221</u> | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>5-26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>JUN 15 1968</u> , and that death occurred at <u>2369</u> M, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>William A. Pillsbury</u> | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5-28-68</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>WILLIAM A. PILLSBURY</u> | | | 22d. ADDRESS
<u>Towson, Md.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5/29/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Stephens Church</u> | |
| 23d. LOCATION (City, town or county)
<u>Bradshaw</u> | | (State)
<u>Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 31 1968</u> | |
| 24. FUNERAL DIRECTOR
<u>John Burns Sons</u> | | ADDRESS
<u>Towson, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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| 1908 | 1907 | 1906 | 1905 | 1904 | 1903 | 1902 | 1901 | 1900 | 1899 | 1898 | 1897 | 1896 | 1895 | 1894 | 1893 | 1892 | 1891 | 1890 | 1889 | 1888 | 1887 | 1886 | 1885 | 1884 | 1883 | 1882 | 1881 | 1880 | 1879 | 1878 | 1877 | 1876 | 1875 | 1874 | 1873 | 1872 | 1871 | 1870 | 1869 | 1868 | 1867 | 1866 | 1865 | 1864 | 1863 | 1862 | 1861 | 1860 | 1859 | 1858 | 1857 | 1856 | 1855 | 1854 | 1853 | 1852 | 1851 | 1850 | 1849 | 1848 | 1847 | 1846 | 1845 | 1844 | 1843 | 1842 | 1841 | 1840 | 1839 | 1838 | 1837 | 1836 | 1835 | 1834 | 1833 | 1832 | 1831 | 1830 | 1829 | 1828 | 1827 | 1826 | 1825 | 1824 | 1823 | 1822 | 1821 | 1820 | 1819 | 1818 | 1817 | 1816 | 1815 | 1814 | 1813 | 1812 | 1811 | 1810 | 1809 | 1808 | 1807 | 1806 | 1805 | 1804 | 1803 | 1802 | 1801 | 1800 | 1799 | 1798 | 1797 | 1796 | 1795 | 1794 | 1793 | 1792 | 1791 | 1790 | 1789 | 1788 | 1787 | 1786 | 1785 | 1784 | 1783 | 1782 | 1781 | 1780 | 1779 | 1778 | 1777 | 1776 | 1775 | 1774 | 1773 | 1772 | 1771 | 1770 | 1769 | 1768 | 1767 | 1766 | 1765 | 1764 | 1763 | 1762 | 1761 | 1760 | 1759 | 1758 | 1757 | 1756 | 1755 | 1754 | 1753 | 1752 | 1751 | 1750 | 1749 | 1748 | 1747 | 1746 | 1745 | 1744 | 1743 | 1742 | 1741 | 1740 | 1739 | 1738 | 1737 | 1736 | 1735 | 1734 | 1733 | 1732 | 1731 | 1730 | 1729 | 1728 | 1727 | 1726 | 1725 | 1724 | 1723 | 1722 | 1721 | 1720 | 1719 | 1718 | 1717 | 1716 | 1715 | 1714 | 1713 | 1712 | 1711 | 1710 | 1709 | 1708 | 1707 | 1706 | 1705 | 1704 | 1703 | 1702 | 1701 | 1700 | 1699 | 1698 | 1697 | 1696 | 1695 | 1694 | 1693 | 1692 | 1691 | 1690 | 1689 | 1688 | 1687 | 1686 | 1685 | 1684 | 1683 | 1682 | 1681 | 1680 | 1679 | 1678 | 1677 | 1676 | 1675 | 1674 | 1673 | 1672 | 1671 | 1670 | 1669 | 1668 | 1667 | 1666 | 1665 | 1664 | 1663 | 1662 | 1661 | 1660 | 1659 | 1658 | 1657 | 1656 | 1655 | 1654 | 1653 | 1652 | 1651 | 1650 | 1649 | 1648 | 1647 | 1646 | 1645 | 1644 | 1643 | 1642 | 1641 | 1640 | 1639 | 1638 | 1637 | 1636 | 1635 | 1634 | 1633 | 1632 | 1631 | 1630 | 1629 | 1628 | 1627 | 1626 | 1625 | 1624 | 1623 | 1622 | 1621 | 1620 | 1619 | 1618 | 1617 | 1616 | 1615 | 1614 | 1613 | 1612 | 1611 | 1610 | 1609 | 1608 | 1607 | 1606 | 1605 | 1604 | 1603 | 1602 | 1601 | 1600 | 1599 | 1598 | 1597 | 1596 | 1595 | 1594 | 1593 | 1592 | 1591 | 1590 | 1589 | 1588 | 1587 | 1586 | 1585 | 1584 | 1583 | 1582 | 1581 | 1580 | 1579 | 1578 | 1577 | 1576 | 1575 | 1574 | 1573 | 1572 | 1571 | 1570 | 1569 | 1568 | 1567 | 1566 | 1565 | 1564 | 1563 | 1562 | 1561 | 1560 | 1559 | 1558 | 1557 | 1556 | 1555 | 1554 | 1553 | 1552 | 1551 | 1550 | 1549 | 1548 | 1547 | 1546 | 1545 | 1544 | 1543 | 1542 | 1541 | 1540 | 1539 | 1538 | 1537 | 1536 | 1535 | 1534 | 1533 | 1532 | 1531 | 1530 | 1529 | 1528 | 1527 | 1526 | 1525 | 1524 | 1523 | 1522 | 1521 | 1520 | 1519 | 1518 | 1517 | 1516 | 1515 | 1514 | 1513 | 1512 | 1511 | 1510 | 1509 | 1508 | 1507 | 1506 | 1505 | 1504 | 1503 | 1502 | 1501 | 1500 | 1499 | 1498 | 1497 | 1496 | 1495 | 1494 | 1493 | 1492 | 1491 | 1490 | 1489 | 1488 | 1487 | 1486 | 1485 | 1484 | 1483 | 1482 | 1481 | 1480 | 1479 | 1478 | 1477 | 1476 | 1475 | 1474 | 1473 | 1472 | 1471 | 1470 | 1469 | 1468 | 1467 | 1466 | 1465 | 1464 | 1463 | 1462 | 1461 | 1460 | 1459 | 1458 | 1457 | 1456 | 1455 | 1454 | 1453 | 1452 | 1451 | 1450 | 1449 | 1448 | 1447 | 1446 | 1445 | 1444 | 1443 | 1442 | 1441 | 1440 | 1439 | 1438 | 1437 | 1436 | 1435 | 1434 | 1433 | 1432 | 1431 | 1430 | 1429 | 1428 | 1427 | 1426 | 1425 | 1424 | 1423 | 1422 | 1421 | 1420 | 1419 | 1418 | 1417 | 1416 | 1415 | 1414 | 1413 | 1412 | 1411 | 1410 | 1409 | 1408 | 1407 | 1406 | 1405 | 1404 | 1403 | 1402 | 1401 | 1400 | 1399 | 1398 | 1397 | 1396 | 1395 | 1394 | 1393 | 1392 | 1391 | 1390 | 1389 | 1388 | 1387 | 1386 | 1385 | 1384 | 1383 | 1382 | 1381 | 1380 | 1379 | 1378 | 1377 | 1376 | 1375 | 1374 | 1373 | 1372 | 1371 | 1370 | 1369 | 1368 | 1367 | 1366 | 1365 | 1364 | 1363 | 1362 | 1361 | 1360 | 1359 | 1358 | 1357 | 1356 | 1355 | 1354 | 1353 | 1352 | 1351 | 1350 | 1349 | 1348 | 1347 | 1346 | 1345 | 1344 | 1343 | 1342 | 1341 | 1340 | 1339 | 1338 | 1337 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892 | 891 | 890 | 889 | 888 | 887 | 886 | 885 | 884 | 883 | 882 | 881 | 880 | 879 | 878 | 877 | 876 | 875 | 874 | 873 | 872 | 871 | 870 | 869 | 868 | 867 | 866 | 865 | 864 | 863 | 862 | 861 | 860 | 859 | 858 | 857 | 856 | 855 | 854 | 853 | 852 | 851 | 850 | 849 | 848 | 847 | 846 | 845 | 844 | 843 | 842 | 841 | 840 | 839 | 838 | 837 | 836 | 835 | 834 | 833 | 832 | 831 | 830 | 829 | 828 | 827 | 826 | 825 | 824 | 823 | 822 | 821 | 820 | 819 | 818 | 817 | 816 | 815 | 814 | 813 | 812 | 811 | 810 | 809 | 808 | 807 | 806 | 805 | 804 | 803 | 802 | 801 | 800 | 799 | 798 | 797 | 796 | 795 | 794 | 793 | 792 | 791 | 790 | 789 | 788 | 787 | 786 | 785 | 784 | 783 | 782 | 781 | 780 | 779 | 778 | 777 | 776 | 775 | 774 | 773 | 772 | 771 | 770 | 769 | 768 | 767 | 766 | 765 | 764 | 763 | 762 | 761 | 760 | 759 | 758 | 757 | 756 | 755 | 754 | 753 | 752 | 751 | 750 | 749 | 748 | 747 | 746 | 745 | 744 | 743 | 742 | 741 | 740 | 739 | 738 | 737 | 736 | 735 | 734 | 733 | 732 | 731 | 730 | 729 | 728 | 727 | 726 | 725 | 724 | 723 | 722 | 721 | 720 | 719 | 718 | 717 | 716 | 715 | 714 | 713 | 712 | 711 | 710 | 709 | 708 | 707 | 706 | 705 | 704 | 703 | 702 | 701 | 700 | 699 | 698 | 697 | 696 | 695 | 694 | 693 | 692 | 691 | 690 | 689 | 688 | 687 | 686 | 685 | 684 | 683 | 682 | 681 | 680 | 679 | 678 | 677 | 676 | 675 | 674 | 673 | 672 | 671 | 670 | 669 | 668 | 667 | 666 | 665 | 664 | 663 | 662 | 661 | 660 | 659 | 658 | 657 | 656 | 655 | 654 | 653 | 652 | 651 | 650 | 649 | 648 | 647 | 646 | 645 | 644 | 643 | 642 | 641 | 640 | 639 | 638 | 637 | 636 | 635 | 634 | 633 | 632 | 631 | 630 | 629 | 628 | 627 | 626 | 625 | 624 | 623 | 622 | 621 | 620 | 619 | 618 | 617 | 616 | 615 | 614 | 613 | 612 | 611 | 610 | 609 | 608 | 607 | 606 | 605 | 604 | 603 | 602 | 601 | 600 | 599 | 598 | 597 | 596 | 595 | 594 | 593 | 592 | 591 | 590 | 589 | 588 | 587 | 586 | 585 | 584 | 583 | 582 | 581 | 580 | 579 | 578 | 577 | 576 | 575 | 574 | 573 | 572 | 571 | 570 | 569 | 568 | 567 | 566 | 565 | 564 | 563 | 562 | 561 | 560 | 559 | 558 | 557 | 556 | 555 | 554 | 553 | 552 | 551 | 550 | 549 | 548 | 547 | 546 | 545 | 544 | 543 | 542 | 541 | 540 | 539 | 538 | 537 | 536 | 535 | 534 | 533 | 532 | 531 | 530 | 529 | 528 | 527 | 526 | 525 | 524 | 523 | 522 | 521 | 520 | 519 | 518 | 517 | 516 | 515 | 514 | 513 | 512 | 511 | 510 | 509 | 508 | 507 | 506 | 505 | 504 | 503 | 502 | 501 | 500 | 499 | 498 | 497 | 496 | 495 | 494 | 493 | 492 | 491 | 490 | 489 | 488 | 487 | 486</ |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 574
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Nan | | | First Nan Middle Last Reibert | | | 2a. DATE OF DEATH
Month May Day 10 , Year 1968 | | 2b. HOUR
11:45 a. M | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
February 14, 1895 | | 6. AGE (In years last birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. XXXXXX NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. COUNTY
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1733 Smallwood St. | | | |
| 14. FATHER'S NAME
First Unknown Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Unknown Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
213-05-9696 | | 17. INFORMANT
Address Records: Spring Grove State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Heart Dis. 2 wks.
4/20
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis, Generalized, Senile 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221
(c)
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Azotemia secondary to arteriolar nephrosclerosis. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec. 16, 1960 , to May 10, 1968 , that (1) (we) lost
saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (1) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-10-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22e. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-13-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAY 13 1968 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

18730

UNITED STATES DEPARTMENT OF AGRICULTURE

18730

Sex

White

Female

Virginia

U.S.

Colonial

Spring Grove State Hospital

Nonpareil

Virginia

18730

Spring Grove State Hospital

U.S. Department of Agriculture

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

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Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

Spring Grove State Hospital, Virginia

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|------------------|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print) Alois (none) Reitenauer | | | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month 5 Day 11 Year 1968 | | 2b. HOUR M |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 6/6/00 | 6. AGE (In years last birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Germany | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Silver Finisher | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME First Leonhard Middle Reitenauer Lost | | 15. MOTHER'S MAIDEN NAME First Middle Unknown Lost | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16b. SOCIAL SECURITY NO. 216-05-4084A | | 17. INFORMANT Mrs. Doris T. Reitenauer | | ADDRESS (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary Occlusion Sudden
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 5/11/68 | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/14/68. | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery | |
| 23d. LOCATION (City or Town) Baltimore, Md. | | 23e. REC'D BY REGISTRAR MAY 13 1968 | | 23f. REGISTRAR'S SIGNATURE Charles Judge | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto Md. 21214 | | ADDRESS | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13b-c film 401
6-21-68 mt

06782

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06789

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Bertha May Hughes Reynolds | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year
May 7, 1968 | | | 2b. HOUR
3:10 M | | |
| 3. SEX
female | | | 4. RACE
white | | | 5. DATE OF BIRTH
May 16, 1897 | | | 6. AGE (In years last birthday)
70 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Pr. Geo. | | | 13c. CITY OR TOWN
Laurel | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 13e. STREET AND NUMBER
Barber's Trailer Park | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
175-18-7135-T | | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | Address. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordian Arrest
4120
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Phenothiazine Hypertension | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from July 30, 1959 , to May 7, 1968 , that (I) (we) lost saw the deceased alive on May 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Fisher M.D. | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5/7/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert Fisher, M.D. | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | | |
| 23a. BURIAL CREMATION
Burial (Specify) | | | 23b. DATE
23-May 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | | 23d. LOCATION (City or Town) (County) (State)
Old Frederick Road Baltimore | | |
| 24. FUNERAL DIRECTOR
Klaus Trumpf | | | ADDRESS
1216 S Chasen St | | | 25a. REC'D BY REGISTRAR
DATE
MAY 27 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

MEDICAL CERTIFICATION

22723



RECEIVED
FEB 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|-----------------------|---|---|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Mary Louise Rieck | | | | | | May 30 1968 | | 9:30 P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Female | | White | | February 6, 1882 | | 86 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Baltimore | | U.S.A. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Augsburg Lutheran Home | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Caroline | | Preston | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | ----- | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Frederick W. Koch | | | Louise Hoffsommer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 217-48-6180-01 | | Paul A. Hauer, Supt. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> | | | | | | | | 5 days | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> | | | | | | | | -4 yrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4200 Generalized Arterio-sclerotic</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1965, to May 30, 1968, that (I) was last saw the deceased alive on May 29 - 1968, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| Earl L. Chambers M.D. | | 5/30/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| Earl L. Chambers - M.D. | | 4108 Liberty St. Baltimore | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| Burial | | June 2, 1968 | | Junior order Cemetery | | Preston, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Paul A. Neumann | | 6067 Harford Ave | | JUN 5 1968 | | Charles Judge | | | | |

MEDICAL CERTIFICATION

10770

10770



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06784

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06784

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
JOSEPH COOLEY RIMMER | | | 2a. DATE OF DEATH
Month Day Year
MAY 31, 1968 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
3 3 99 | | 6. AGE (In years lost birthday)
69 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOSPITAL VETERANS ADMINISTRATION | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
WATERMAN | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | 13b. COUNTY
TALBOT | 13c. CITY OR TOWN
TILGHMAN IS. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
TILGHMAN ISLAND, MD | |
| 14. FATHER'S NAME First Middle Last
OWEN GOODWIN RIMMER | | 15. MOTHER'S MAIDEN NAME First Middle Last
AMELIA FRANCIS NIBBLET | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16b. SOCIAL SECURITY NO.
UNKN. | 17. INFORMANT Address
CLINICAL RECORDS, VA HOSP, FT HOWARD, MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION, OLD AND RECENT
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS, SEVERE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 5/13/68 , 19____, to 5/31/68 , 19____, that (X) (we) lost saw the deceased alive on 5/31/68 , 19____, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ahmed Kuty DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/31/68 | |
| 22d. PHYSICIAN'S NAME (Type)
AHMED C. KUTTY, M. D. | | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE
6/3/1968 | 23c. NAME OF CEMETERY OR CREMATORY
Holmes Cemetery | 23d. LOCATION (City or Town) (County) (State)
Tilghman, Md. | | |
| 24. FUNERAL DIRECTOR
Maurice G. Remington & Son, Easton, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-1015 (4)
30M REV. 1/68

1
06785

106792

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
JOHN WILLIAM RINGSDORF | | | 2a. DATE OF DEATH
Month Day Year
5 28 68 | | | 2b. HOUR
M
M | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
March 30, 1886 | | 6. AGE (In years
lost birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Greater Balto. Med. Center | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Machinist | | 12b. KIND OF BUSINESS OR
INDUSTRY
Continental Ca. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Lutherville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
122 Ridgely Rd. | |
| 14. FATHER'S NAME First Middle Last
Charles P. Ringsdorf | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lavina Snyder | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
215-03-3750 | | 17. INFORMANT
Ethel M. Wolferman - 122 Ridgely Rd. | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
1530
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) <u>Adenocarcinoma of cecum</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1530 | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14, 1968, to 5/28, 1968, that (I) (we) last
saw the deceased alive on 5/28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Rudiger Breitenecker | | DEGREE
M.D. | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/28/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Rudiger Breitenecker, M. D. | | 22e. ADDRESS
Greater Baltimore Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5-31-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Road-21206 | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

00100

00100

Robertson

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06786

CERTIFICATE OF DEATH

06793

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
May Starr Robins | | | 2a. DATE OF DEATH Month Day Year
May 28 1968 | | | 2b. HOUR
2 P M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
May 13, 1880 | | 6. AGE (In years last birthday)
88 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chapel Hill Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3913 Chatham Rd. | |
| 14. FATHER'S NAME First Middle Last
Harry Starr | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Hinds | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown
NO | | 16b. SOCIAL SECURITY NO.
215-05-1325 | | 17. INFORMANT Address
Reginald S. Robins. East Orleans, Mass. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4129 arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Several yrs.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4200</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> to <u>28 May 1968</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>29 May 1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Paul H. Royse</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>May 28 '68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
PAUL H. ROYSE MD | | | | 22e. ADDRESS
1403 FOLEY LANE PIKESVILLE, MD 21208 | | | |
| 23a. BURIAL, CREMATION, <u>Burial</u> (Specify) | | 23b. DATE
May, 31, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md | |
| 24. FUNERAL DIRECTOR
<u>Harry N. Armistead</u> | | ADDRESS
4204 Ridgewood Ave. Baltimore, Md. 21215 | | 25a. REC'D BY REGISTRAR
MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div style="text-align: center;"> 06787
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | |
|---|--|--|--|--|--|---|--|-----------------------------------|--|---------|
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Annie | | | E. Rush | | | May 31, 1968 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | May 8, 1887 | | 81 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Balto. Md. | | U. S. A. | | | | Balto. Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Lansdowne | | | 3113 Aspen Court | | | House Wife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Balto. | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3113 Aspen Court | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| John G. Eberling | | | Margaret Stevens | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | 220-56-1538 | | Lansdowne, Md. Address
Mr. George F. Rush Jr. 3113 Aspen Court | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u>
<u>250.9</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>hypertensive Cardio Vascular D.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes Mellitus</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>weakly</u>
<u>1/2</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>260x</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-22-1962</u> , to <u>5-30-1968</u> , that (I) (we) lost saw the deceased alive on <u>5-30-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Florian P. Nadolski</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5-31-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Florian P. Nadolski</u> | | | | | 22e. ADDRESS
<u>2619 Hammond Ferry Rd 21227</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | June 3, 1968 | | Loudon Park Cem. | | Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave, Balto. Md. | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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Page 10 of 10

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James A. Smith

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• *Journal of the American Medical Association*, 1997; 278: 1033-1038

• 204 •

[illegible]

The chemical structure of 2,2,4,4-tetrafluorobenzophenone (TFB) is shown. It consists of a central carbonyl group (C=O) bonded to two phenyl rings. The phenyl ring on the left is substituted with two fluorine atoms at the 2 and 4 positions. The phenyl ring on the right is substituted with two fluorine atoms at the 2 and 4 positions.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

06788 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a, Film #G401 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06795

| | | | | | | | | | | | |
|--|---------|------------------|--|-----------------------------|-----------------------------|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR | | |
| WILLIAM | | | R. | | | SANN Sr. | | | May 15 19 68 M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | | | 2d. HOUR | | |
| Male | White | July 19, 1903 | 64 YRS. | | | May 15, 19 68 | | | 9:25 PM | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Baltimore | | | U. S. A. | | | | | | BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Dr. James G. Saffell (office) | | | Weighmaster | | | Kerr-McGee | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Md. | | | BALTIMORE | | | Baltimore | | | 7425 Berkshire Road | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| John H. Sann | | | Helen Dilley | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 215-05-8476 | | | Mrs. Dorothy M. Sann | | | 7425 Berkshire Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | | Charles S. Springate, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED May 16, 1968 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 5-18-1968 | | | Sacred Heart | | | Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | 25a. REC'D BY REGISTRAR DATE MAY 17 1968 | | | 25b. REGISTRAR'S SIGNATURE | | |

10732

10732

U.S. AIR FORCE

10732

July 22, 1953

Belmont, U.S.A.

Belmont

John R. Brennan

Belmont

21-07-0170 Mrs. Dorothy M. Brennan

21-07-0170 Mrs. Dorothy M. Brennan

6-18-1953

Belmont, U.S.A.

Belmont, U.S.A.

July 8, 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Amelia C. Schaar | | | | | | Month Day Year | | | 33 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | 7. IF UNDER 1 YEAR | |
| Female | | White | | 5-10-84 | | 84 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S. of A. | | | | Baltimore County Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. County, Md. | | Aged Menor Women's Home | | Practical Nurse | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Balto. Md. | | | No. | | Balto. 21229 | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1107 Haverhill Rd. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Alvin Schaar | | | Catherine Reimbach | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| no. | | | 216-24-3428 | | Frances M. Stueffus | | 615 Chestnut Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct | | | | | | | | 72 hrs | |
| 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, Diabetes mellitus | | | | | | | | 10 + yrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August, 1958, to May 9, 1968, that (I) (we) last saw the deceased alive on 5/15/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | |
| Newland E. Day M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/13/68 | | Loudon Park | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. Cook | | | | Brooks West Inc Balt. Md. 21228 | | DATE MAY 15 1968 | | Charles Judge | |

10133

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3 1

06799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
06797

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print)
First Christopher Middle Carl Last Schattall | | | 2a. DATE OF DEATH
Month May Day 1 Year 1968 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
April 14, 1958 | | 6. AGE (In years last birthday)
10 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Pikesville 8, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1010 Kingston Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
School | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Pikesville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1010 Kingston Rd. | |
| 14. FATHER'S NAME First Middle Last
Julius Frederick Schattall | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lieselotte Kimmel | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
None | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Julius F. Schattall | | Address Pikesville 8, Md.
1010 Kingston Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>malignancy of brain</u>
191X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1930 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>May 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>1 May 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Paul H Royse MD</u> | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Paul H Royse</u> | | 22e. ADDRESS
<u>1403 Foley Lane Pikesville Md</u> | | 22c. DATE SIGNED
<u>2 May 68</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>May 3, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lake View Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Randallstown Baltio. Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Frank H. Newell</u> | | ADDRESS
<u>Pikesville 68</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 7 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

6
66791
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

66798

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type ANN) ESTHER | | First Middle Last | | 2a. DATE OF DEATH
May 14 1968 | | 2b. HOUR
4:29 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
April 2, 1893. | | 6. AGE (In years last birthday)
75 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Armecost Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13e. STREET AND NUMBER
4303 Glenmore Avenue | | 14. FATHER'S NAME
First Middle Last
High McMonamy | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Jane Riley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
220-18-0552 | | 17. INFORMANT
Mrs. Frances Stengle | | Address
(Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 189.0
180x
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Metastasis to Lung-liver & Bone
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 YRS
1 yr. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION
1966 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Redney Veinor | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963 , 19____, to 5/14/68 , 19____, that (I) (we) last saw the deceased alive on 5/13/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Walter E. Karfgin | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/15/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Walter Karfgin | | | | 22e. ADDRESS
4331 Harford Rd., Balto. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/18/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Butler, New Jersey | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. 5305 Harford Rd. | | | | 25a. REC'D BY REGISTRAR
MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Francis Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

06792

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06799

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. LENGTH OF STAY IN It
<u>4 mos.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>8217 Hochmeyer Blvd</u> | | d. STREET ADDRESS
<u>8217 Hochmeyer Blvd</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>JAMES HARRY Scheck</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>6</u> Year <u>1968</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-26-08</u> |
| 9. AGE (In years last birthday)
<u>60</u> yrs. | | 10. IF UNDER 1 year
Months <u>6</u> Days <u>19</u> Hours <u>68</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>National Plastic</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Scheck</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mamie Zimmerman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>217-07-9326</u> | |
| 17. INFORMANT
<u>Mrs Dolores Kirwan</u> | | Address
<u>8726 Oakleigh Rd</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACVD (Arterio-sclerotic Cordis)</u>
4129 DUE TO <u>vascular Disease) - final</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>arterio-sclerotic episode</u>
(c) <u>unmet.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>unmet.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>4221</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>John C. Hyle</u> M.D. | | 22. DATE SIGNED
<u>5-6-68</u> | |
| EXAMINER'S NAME (Type)
<u>JOHN C. Hyle</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) <u>8217 Baltimore</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5/9/68</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Leonard J Ruck Inc. Baltimore, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 7 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>John Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 06794 | | | | | | | | | | |
| 06801 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First MARY Middle ELIZABETH Last SCHNEIDER | | | 2a. DATE OF DEATH
Month MAY Day 4, Year 1968 | | 2b. HOUR
9:55a.m. | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
OCTOBER 4, 1898 | | 6. AGE (In years
lost birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign
country)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON 21204 | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY
Martin Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INCLUDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5705 FENWICK AVENUE 21212 | |
| 14. FATHER'S NAME
First Addison Middle Headley Last | | | 15. MOTHER'S MAIDEN NAME
First Susan Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO.
212-22-0427 | | 17. INFORMANT
George P. Schneider -5705 Fenwick Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u>
450X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. 465X
(b) <u>Pulmonary Thrombo-embolism</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Gastrointestinal hemorrhage due to peptic erosive esophagitis & ulcerative sigmoiditis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 9, 1968, to May 4, 1968, that (we) last saw the deceased alive on May 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Reynaldo Orjuela-Gomez, M.D. | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 5, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS
7620 York Road, Towson 4, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5-7-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Park | | 23d. LOCATION (City or Town)
Balto. Md. | | (County) (State) | | |
| 24. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Rd.-21206 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

42520

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|---------|------------------|--|--------------------------------|--|--|--|--------------------------|--|--|----------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 20. DATE KNOWN OF DEATH MATED | | | 2b. HOUR | | |
| Lisa | | | E | | | Scheurer | | | May 15 1968 3 P M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| F | W | 6-10-1965 | 2 YRS. | II | | | | May 15 1968 3 P M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Baltimore | | | U.S.A | | | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore, Md. | | | St Josephs | | | Baby | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Baltimore | | | Balto, Md | | | 3228 Glendale Avenue | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | |
| Paul | | | Dianna | | | no | | | | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DATE OF OPERATION | | | 20. AUTOPSY? | | |
| Paul Scheurer | | | Strangulation | | | 9365 | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3228 Glendale Avenue | | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 913.9 | | | DUE TO, OR AS A CONSEQUENCE OF | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | |
| | | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| 9365 | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | 21d. LOCATION Street or R.F.D. No. City or Town County State | | |
| 30 | | | May 15 1968 | | | Climbed feet first into storm sewer | | | Caught neck on way down | | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21f. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21g. LOCATION Street or R.F.D. No. City or Town County State | | | 21h. LOCATION Street or R.F.D. No. City or Town County State | | |
| | | | Street | | | Glendale Ave Baltimore Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. DATE SIGNED | | | 22c. CHIEF MEDICAL EXAMINER | | | 22d. DEPUTY MEDICAL EXAMINER | | |
| Charles F. O'Donnell | | | 5/15/68 | | | Charles F. O'Donnell, M.D. | | | Charles F. O'Donnell, M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 5-18-1968 | | | Oak Lawn Cemetery | | | Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | 25c. DATE | | |
| Walter Dabrowski | | | MAY 20 1968 | | | Charles F. O'Donnell | | | MAY 20 1968 | | |
| 1005 Dundalk Avenue | | | | | | | | | | | |

2950

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 06795 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06802 | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| MARGARET ANN SE BOUR | | | | Month MAY Day 27 Year 1968 | | | | 9:30 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| F | | W | | 11-21-1905 | | 62 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CATONSVILLE | | | | 1642 KIRKWOOD RD | | | | HOUSEWIFE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD. | | | | BALTIMORE | | CATONSVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1642 KIRKWOOD RD | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| CHARLES M. PERRY | | | | | | | | FLAGHERTY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| NO | | | | | | JOHN E. SE BOUR SR. 1642 KIRKWOOD RD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute massive myocardial infarction</u> | | | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>an old myocardial infarction</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic congestive heart failure</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , to <u>May 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stanley Ankadas</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <u>5-28-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>STANLEY ANKADAS</u> | | | | | | | | | | 22e. ADDRESS <u>1101 Maiden Choice Ln, Balto 21229</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| BURIAL | | 5-31-1968 | | NEW CATHEDRAL | | BALTIMORE MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WEBER FUNERAL HOME 5311 EDMONDSON AVE. | | | | | | | | | | DATE <u>May 29 1968</u> | | <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06796

Item#5, Film G401 6/11/68km

06803

1. DECEASED-NAME (Type or print) First Middle Last
Ireda Senger

2a. DATE OF DEATH Month Day Year
May 25, 1968

2b. HOUR
7 A M

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH
Nov. 9, 1895

6. AGE (In years last birthday)
72 YRS.

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (State or foreign country)
Virginia

7b. CITIZEN OF WHAT COUNTRY?
U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH
Baltimore County, Md.

10. CITY OR TOWN OF DEATH
Catonsville

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Ridgeway Manor Nursing Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland

13b. COUNTY
Baltimore

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER
1822 St. Paul Street, Baltimore, Md.

14. FATHER'S NAME First Middle Last
George Franklin Senger

15. MOTHER'S MAIDEN NAME First Middle Last
Sally Andes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No

16b. SOCIAL SECURITY NO.
227-20-4295

17. INFORMANT Ave. Baltimore, Md. Address 21228
Ridgeway Manor Nursing Home 5743 Edmondson

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Leucemia
207.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
2044

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
year

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED White ☐ Not white ☐ at work ☐ Not at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1 Jan, 1967, to 25 May, 1968, that (I) (we) last saw the deceased alive on 25 May, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE William Goodman M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED 27 May 68

22d. PHYSICIAN'S NAME (Type)
William Goodman M. D.

22e. ADDRESS
1334 Sulphurton Rd - 21227

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE
5/29/1968

23c. NAME OF CEMETERY OR CREMATORY
Mt. Horeb Cemetery

23d. LOCATION (City or Town) (County) (State)
Rockingham County, Virginia

24. FUNERAL DIRECTOR
Easton Funeral Home

ADDRESS
Catonsville, Md.

25a. REC'D BY REGISTRAR
DATE MAY 29 1968

25b. REGISTRAR'S SIGNATURE
Charles Judge

363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06797

06804

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|----------------------|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Margaret P. Shamer</i> | | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/> <i>5/25</i> <i>1968</i> | | 2b. HOUR <i>9:10</i> <i>P</i> <i>M</i> | |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>11/16/05</i> | 6. AGE (in years last birthday) <i>62</i> YRS. | 2c. DATE PRONOUNCED DEAD <i>May 25</i> <i>1968</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. |
| 10. CITY OR TOWN OF DEATH <i>Rondellstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore Co. General</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>At Home</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY <i>Balto.</i> | 13c. CITY OR TOWN <i>Rondellstown</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <i>6401 Liberty Rd</i> |
| 14. FATHER'S NAME First <i>Robert</i> Middle <i>Porter</i> Last <i>Porter</i> | | 15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Connelly</i> Last <i>Connelly</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>219-14-1440</i> | | 17. INFORMANT ADDRESS <i>Tilghman Shamer-6401 Liberty Road # 7</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio - Vascular Disease</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4221</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>James N. Frederick</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>5/25/68</i> | |
| EXAMINER'S NAME (Type) <i>James N. Frederick</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) <i>1311 Francis Ave Baltimore, Md 21222</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>5-29-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i> | |
| 24. FUNERAL DIRECTOR | | ADDRESS <i>Ellsworth Armacost-4600 Liberty Hgts. Ave</i> | | 25a. REC'D BY REGISTRAR <i>MAY 28 1968</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>James N. Frederick</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print)
First Middle Last
Louis - Shearer | | | 2a. DATE OF DEATH
Month Day Year
5 22 68 | | | 2b. HOUR
6:30^P | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
6/5/1890 | | 6. AGE (In years lost birthday)
77 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
FROSTBURG, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Pikesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Professional House, Inc | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
PROPRIETOR | | 12b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
Lord Balto. Hotel | | 14. FATHER'S NAME First Middle Last
H. - Shearer | | 15. MOTHER'S MAIDEN NAME First Middle Last
FANNIE ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO.
212-46-8966 | | 17. INFORMANT
MRS. JOSIE SCHWARTZ, 1190 W. BELVEDERE AVE. | | 17. ADDRESS
BELVEDERE TOWERS, APT. 421 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Prostate
185X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
177X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1968 , to 5-22, 1968 , that (I) (we) last saw the deceased alive on 5-20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
David I. Miller | | DEGREE MD. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-22-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
David I. Miller | | 22e. ADDRESS
Owings Mills, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY
MIKRO KODESH-BETH ISRAEL | | 23d. LOCATION (City or Town) (County) (State)
HERRING RUN | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | ADDRESS | | 25a. RECD BY REGISTRAR
MAY 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Young | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06799

06806

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) First EDWIN Middle ANTHONY Last SHERWOOD | | | 2a. DATE OF DEATH
Month 5 Day 28 Year 68 | | 2b. HOUR
9:00A M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
9/20/1896 | | 6. AGE (In years
last birthday)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
BROOKLYN, NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7a. BIRTHPLACE (State or foreign
country)
BROOKLYN, NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. COUNTY OF DEATH
BALTIMORE COUNTY Md. | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
VETERANS ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
AUDITOR | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1504 Upshire Road | | 12b. KIND OF BUSINESS OR
INDUSTRY
MARYLAND STATE | |
| 14. FATHER'S NAME First WILLIAM Middle L. Last SHERWOOD | | 15. MOTHER'S MAIDEN NAME First MARY Middle GARTLAND Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES | | 16b. SOCIAL SECURITY NO.
WWWI 213 09 90 92 | | 17. INFORMANT
Address CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
CARCINOMA OF PHARYNX
IMMEDIATE CAUSE (a) 149X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) 149X
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
149X | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/5/68 , 19____, to 5/28/68 , 19____, that <input checked="" type="checkbox"/> (we) last
saw the deceased alive on 5/28/68 , 19____, and that in our opinion death occurred on the date and hour and from the
causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>George C. McElpatrick</i> DEGREE ATTENDING
PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/28/68 | |
| 22d. PHYSICIAN'S
NAME (Type) GEORGE C. MC ELPATRICK, M. D. | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
6/1/68. | | 23c. NAME OF CEMETERY OR CREMATORY
OAKLAWN CEMETERY | |
| 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | 24. FUNERAL DIRECTOR
Leonard J. Ruck--- ADDRESS
RUCK FUNERAL HOME
HARFORD ROAD, BALTIMORE, MD. | | | |
| 25a. REC'D BY REGISTRAR
DATE MAY 29 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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TO: JAMES C. VOLKMAN, ASSISTANT ATTORNEY GENERAL, U.S. DEPT. OF JUSTICE, WASHINGTON, D.C. 20530

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|---|---|---|----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
GUY | | Middle
SHOOK | | Last
SHOOK | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 19 | | 2b. HOUR AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
6/4/1895 | | 6. AGE (In years lost birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year May 16, 1968 | | 2d. HOUR AM | |
| 7a. BIRTHPLACE (State or foreign country)
Pickaway Co. Ohio | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Co., Md. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Balt. Wash. Expr. south of Daisy Avenue | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Disabled War Veteran | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
N.Y. | | | | 13b. COUNTY
393 Court | | 13c. CITY OR TOWN
Rochester | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
393 Court St. Apts. | | | |
| 14. FATHER'S NAME
First Middle Last
Francis Marion Shook | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Lucilla Cora Woolever | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | | | 16b. SOCIAL SECURITY NO.
(If yes give year or dates of service) W. W. I | | 17. INFORMANT
Columbia, Md. ADDRESS 21043
Mrs. F. Helme Rogers 10075 Windstream Drive | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple traumatic injuries
814.7 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
8124 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
12:30 PM 4-16 19 68 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Pedestrian struck by car | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Expressway 474 south of Baltimore Washington | | | 21f. LOCATION Street or R.F.D. No.
474 south of Daisy Avenue | | | City or Town
Baltimore | | State
Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
May 16, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/20/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Easton Funeral Home | | | | ADDRESS
Catonsville, Md. | | | | 25a. REC'D BY REGISTRAR
MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>Item 28 film 401 5-29-68</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06801</div> <div>06808</div> | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) LEROY | | | | First A. Middle SHRADER, SR. Last | | | | 2a. DATE OF DEATH
May Month 15 , Day 1968 | | | 2b. HOUR
3:00 A.M. |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
October 12, 1908 | | | 6. AGE (In years last birthday)
59 YRS. | | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Lansdowne | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3305 Kessler Court | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Chauffeur | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lansdowne | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3305 Kessler Court | | | |
| 14. FATHER'S NAME First Elmer Middle Shrader Last | | | | 15. MOTHER'S MAIDEN NAME First (Unknown) Middle Baker Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
213-10-0527 | | 17. INFORMANT
Mr. Leroy A. Shrader, Jr., | | | | Address 21209 2104 Smith Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
1621 DUE TO, OR AS A CONSEQUENCE OF
Squamous Cell Carcinoma left main stem
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bronchus
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
1621 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 62 to 5/15 , 19 68 , that (I) (we) last saw the deceased alive on 5/15 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James N. Frederick DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/16/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. James N. Frederick | | | | 22e. ADDRESS
1311 Francis Avenue, Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print)
John Sloan | | | 2a. DATE OF DEATH
Month 5 Day 17 Year 68 | | | 2b. HOUR
6 p M | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
Oct. 27, 1904 | | 6. AGE (In years
lost birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Arbutus | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
5112 Leeds Ave. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
developer | | 12b. KIND OF BUSINESS OR
INDUSTRY
electronic | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5112 Leeds Ave. | |
| 14. FATHER'S NAME First Middle Last
David Sloan | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Houston Sloan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) yes | | 16b. SOCIAL SECURITY NO.
W.W.11 014 05 4211 | | 17. INFORMANT Address
Mary E. Sloan 5112 Leeds Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular Disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
 sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, natify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24, 1956 to 5/17, 1968 , that (I) (we) last
saw the deceased alive on 5/17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James N. Frederick | | | | 22c. DATE SIGNED
5/24/68 | | 22d. PHYSICIAN'S
NAME (Type) James N. Frederick | | | |
| 22e. ADDRESS
1311 Francis Ave. 21227 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
UNKNOWN (Specify) | | 23b. DATE
May 21, 68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
Ambrose Inc. 1328 Sulphur Spring Rd. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|--|---|--|------------------------------------|--|-------------------|--|
| 06803 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06810 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Anna | | Elizabeth | | Smith | | May | | Month Day Year | | 30 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| F | | W | | 6/22/1891 | | 76 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Sweden | | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore 12 | | Armacost N.H. | | Homemaker | | Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Balto. | | 21218 | | | | 624 Parkwyth Ave. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| John | | Johanson | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 216-05-7589 | | E. Frederick Smith | | (Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>
<u>191X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>of Brain</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 Months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>1930</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19, 1968</u> , to <u>5/28, 1968</u> , that (I) (we) last saw the deceased alive on <u>5/26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Charles F. O'Donnell</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/29/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Dr. Charles F. O'Donnell | | 7501 York Road | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 5/31/68 | | Dulaney Valley Mem. Grds. | | Timonium, Balto. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| H.W. Jenkins & Sons Co. | | 4905 York Rd. Balto. 12, Md. | | MAY 31 1968 | | <u>Charles Judge</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|---------------------|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First
ELMER | Middle
M. | Last
SNELLING | 20. DATE OF DEATH
Month 5 Day 6 Year 68 | | | 2b. HOUR
1:15 PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7/14/05 | | 6. AGE (In years last birthday)
62 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0
IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
USA | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2935 Manns Avenue | |
| 14. FATHER'S NAME
First HENRY Middle SNELLING Last SNELLING | | 15. MOTHER'S MAIDEN NAME
First ALICE Middle LENDIS Last LENDIS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (specify) WW II (If specify war, dates of service) | | 16b. SOCIAL SECURITY NO.
215 07 30 19 | | 17. INFORMANT Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) SEPTICEMIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)
4200 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (it) (this hospital) attended the deceased from 5/5/68 , 19 68 , to 5/6/68 , 19 68 , that (it) (we) last saw the deceased alive on 5/6/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (it) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ahmed Kutty MD | | 22c. DATE SIGNED
5/6/68 | | 22d. PHYSICIAN'S NAME (Type)
AHMED C. K. KUTTY, M.D. | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)
BURIAL | | 23b. DATE
5-9-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE, NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
CHARLES F. EVANS FUNERAL HOME | | 25. REC'D BY REGISTRAR
9 1968 | | 25a. DATE
5/6/68 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

0930

James K. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) George Adolph Sommerman | | | 2a. DATE OF DEATH
5 Month 21 Day 1968 | | | 2b. HOUR
2 ^{PM} | |
| 3. SEX
male | | 4. RACE
W | | 5. DATE OF BIRTH
June 27, 1883 | | 6. AGE (In years last birthday)
84 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Balto, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Kingsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cedar Lane | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Lt-Fire Dept-retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Kingsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
Cedar Lane | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Daniel Sommerman | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Phillipina Bachman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO.
216-28-4647 | | 17. INFORMANT Address
Mrs. Emma E. Sommerman, Kingsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of Stomach
151.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
151X | | | | | | | |
| 19a. DATE OF OPERATION
3-14-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastric obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960 , to May 21, 1968 , that (I) (we) lost saw the deceased alive on May 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
William A. Tyson DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
5-21-68 | |
| 22d. PHYSICIAN'S NAME (Type)
William A. Tyson | | | | 22e. ADDRESS
Kingsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
5/23/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc... Balto, Md. 14 | | | | 25a. RECD. BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

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EXHIBIT OF DEATH

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|--|---------|--|----------|---|---|---|---|--|----------|----------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Lost | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> Month | Day | Year | 2b. HOUR |
| Guy | | | Alton | Spangler | 5/5 | | 48 | 7:30 | PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| M | W | 4/2/84 | | 76 YRS. | MONTHS | DAYS | MONTH | Day | Year | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | <input checked="" type="checkbox"/> NEVER MARRIED | 9. COUNTY OF DEATH | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| Reverstown, W. Va. | | U.S.A. | | WIDOWED | <input type="checkbox"/> | DIVORCED | <input checked="" type="checkbox"/> | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. STREET AND NUMBER | | |
| Randallstown, Md. | | Baltimore Co. General | | Engineer | | Sinai Hosp. | | 3135 Adel Ave | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| md. | | Balto | | Baltimore, Md. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3135 Adel Ave | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost | |
| James Edward | | | Spangler | | Martha | | Clementine | Grotty | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| NO | | 215-24-6084 | | Mrs. Lucille S. Nicholson | | 4501 Dresden Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4221 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 21d. INJURY OCCURRED | | | | |
| CAUSE OF DEATH | | HOUR A.M. | | 19 | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion death resulted from: | | |
| Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | |
| ACTUAL SIGNATURE | | James N. Frederick MD. | | CHIEF MEDICAL EXAMINER | | ASSISTANT MEDICAL EXAMINER | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | James N. Frederick MD | | DEPUTY MEDICAL EXAMINER | | 1311 Francis Ave | | 5/6/68 | | |
| ADDRESS (Street, city, town, or county) | | Baltimore, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | May 8, 1968 | | Druid Ridge Cemetery | | Pikesville | | Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | DATE | | |
| Frank H. Newell | | Pikesville, Md. | | MAY 9 1968 | | Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06807

06814

| | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
FELIX | | | First
JOHN | | | Middle
SPARZAK | | | Last | | | 2a. DATE OF DEATH
Month MAY Day 21 Year 1968 | | | 2b. HOUR
2:30PM | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
2/13/21 | | | 6. AGE (In years last birthday)
47 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
MACHINIST | | | 12b. KIND OF BUSINESS OR INDUSTRY
MACHINE SHOP | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2103 Jefferson Street | | | | | | |
| 14. FATHER'S NAME
First FELIX Middle F. Last SPARZAK | | | 15. MOTHER'S MAIDEN NAME
First ELIZABETH Middle KWIATKOWSKA Last | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
YES | | | 16b. SOCIAL SECURITY NO.
WW II | | | 17. INFORMANT
Address
218 07 78 55 CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
436.9
DUE TO, OR AS A CONSEQUENCE OF
CEREBRAL VASCULAR ACCIDENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9/29/61 , 19__, to 5/21/68 , 19__, that (X) (we) last saw the deceased alive on 5/21/68 , 19__, and that in 1967 (our) opinion a death occurred on the date and hour and from the causes stated above; (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Charles J. Blair</i> | | | | | | | | | | | | | | | 22c. DATE SIGNED
5/21/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
CHARLES J. BLAIR, M. D. | | | | | | | | | | | | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
5-25-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY'S CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Miller</i>
MILLER FUNERAL HOME
JEFFERSON & MONTFORD AVENUE, BALTIMORE, MD. 21205 | | | | | | | | | | | | | | | | | | |

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Yours sincerely,

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• 100% Satisfaction

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UNCLASSIFIED//FOR OFFICIAL USE ONLY

CHARLES W. BAKER, D.

WATER, MONTH

WOLFF, RICHARD

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) ALAN | | First | | Middle | | Last | | 20. DATE KNOWN OF DEATH
ESTIMATED <input type="checkbox"/> May 18, 1968 | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 23, 1937 | | 6. AGE (In years last birthday)
30 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month May Day 18 , Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
419 Oakwood Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Machine Operator - Manganese Chem. | | 12b. KIND OF BUSINESS OR INDUSTRY
Co. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
419 Oakwood Rd. | | | |
| 14. FATHER'S NAME
Henry | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME
Bessie | | First Middle Last
Milam | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
190-28-0009 | | 17. INFORMANT (Wife)
Mrs. Betty Sprouse | | ADDRESS
Md. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease
4120
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | |
| 21a. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Edward F. Wilson
EXAMINER'S NAME (Type) | | M.D.
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
May 19, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/21/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Dorsey, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
John J. Duda | | ADDRESS
7922 Wise Ave. Dundalk, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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WORLD TALKING & TELETYPE CO. INC.

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June 22, 1954

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or Print) MARY First M Middle Stavis Last | | | 2a. DATE OF DEATH
Month 5 Day 24 Year 1968 | | | 2b. HOUR
3:15 P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
April 14, 1882 | | 6. AGE (in years
last birthday) 86 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign
country) Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Summit Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY at Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1243 James St. | | |
| 14. FATHER'S NAME First Anthony Middle Mazicka Last Ann | | | 15. MOTHER'S MAIDEN NAME First Ann Middle Czapulatis Last Ann | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
✓ | | 17. INFORMANT Address
Mr Thomas - A. Stavis 1243 James St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease
4129
DUE TO, OR AS A CONSEQUENCE OF congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple decubitus ulcers
DUE TO, OR AS A CONSEQUENCE OF fractured right hip
(c) fractured right hip | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION
5/16/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
hernia repair | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16, 1968 to 5/24, 1968 , that (I) (we) last saw the deceased alive on 5/23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
E. KAJAVIDIS, M.D. | | | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/24/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) 1801 FREDERICK RD BALTO 21228 | | | | 22e. ADDRESS
E. KAJAVIDIS, M.D. | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
5/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Can. | | 23d. LOCATION (City or Town) (County) (State)
4430 Belair Rd. Md. | | | | | |
| 24. FUNERAL DIRECTOR
John J. Howard & Sons | | | | ADDRESS
401 Halling St. Baltimore, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE
James Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAY 21 1968 | | | | | | | | | | |
|--|--|--|--|--|---|---|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <div>06810</div> <div> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> <div>06817</div> </div> | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Edith | | | Steele | | | Month 5 Day 19 Year 68 | | 10:20A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| F | | W | | 11/23/1876 | | 91 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| England | | USA | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | Stella Maris Hospice | | | Hswf | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | | | | Baltimore | | | | 4301 Roland Ave., | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| George Heorrell | | | Mercy Jordan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | 215-54-1555 | | Mrs. Otis M. Travers (Hospice records) 1524 Medford Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4129 G.C. Hemorrhage, Cause Unknown | | | | | | | | | 1 dy. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4221 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22/66, 19__, to 5/19/68, 19__, that (I) (we) last saw the deceased alive on 5/18/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| Robert J. Mahon, M.D. | | 5/20/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| | | 204 E. Joppa Rd | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5/21/68 | | Parkwood | | Parkville, Balto. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | DATE | | 25b. REGISTRAR'S SIGNATURE | | | | |
| H. W. Jenkins & Sons Co. | | 4905 York Road Baltimore 12, Md. | | MAY 21 1968 | | Charles Judge | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06811

Frank

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06818

| | | | | | | | | |
|---|--|--|--|---|----------------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
Frank A. Stokes Sr. | | | 2a. DATE OF DEATH Month Day Year
5 5 68 | | | 2b. HOUR
11:04 P.M. | | |
| 3. SEX
Male | | 4. RACE
Cauc | | 5. DATE OF BIRTH
10-14-99 | | 6. AGE (In years last birthday)
68 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Balto, Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Balto. Med. Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Pipe fitter (retired) | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13e. STREET AND NUMBER
24 Decatur Ave. | | | 12b. KIND OF BUSINESS OR INDUSTRY
CIVIL SERVICE | | | | | |
| 14. FATHER'S NAME First Middle Last
John E Stokes | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Stokes CARY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
No | | | 16b. SOCIAL SECURITY NO.
216-44-7532 | | 17. INFORMANT
Patient's chart | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621 Metastasis to bones + brain
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the lung
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO-DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163X | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-10, 1968, to 5-5, 1968, that (we) last saw the deceased alive on 11:04 PM 5-5-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Jose M. De Leon, M.D. | | 22c. DATE SIGNED
5-5-68 | | 22d. PHYSICIAN'S NAME (Type)
JOSE M. DE LEON, M.D. | | | | |
| 22e. ADDRESS
GBMC | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5-9-68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln | | 23d. LOCATION (City or Town) (County) (State)
BHADEUSBURG MD. | | |
| 24. FUNERAL DIRECTOR
John M. Taylor & Sons | | ADDRESS
Annapolis, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

06815

Committee of the Land
Producers to Power & Water



FOR M. W. 100, M.D. CHANC
FOR M. W. 100, M.D. CHANC

FOR M. W. 100, M.D. CHANC
FOR M. W. 100, M.D. CHANC

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|-------------------------|---|---|--|---|---|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
Jackson | | Middle
Ross | | Last
Stott | | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
April 1, 1950 | 6. AGE (In years last birthday)
18 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | 2a. DATE KNOWN OF ESTI-DEATH MATED
May 2nd 1968 | 2b. HOUR
7:15 M. | | |
| 7a. BIRTHPLACE (State or foreign country)
Delaware | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph's Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
High School | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5804 The Alameda | | |
| 14. FATHER'S NAME
First
Jack | | | Middle
R. | | Last
Stott | | 15. MOTHER'S MAIDEN NAME
First
Pauline | | | Middle
Miller | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | 17. INFORMANT
Mrs. Pauline M. Stott (Same as 13) | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Depressed Temporal Fractured Skull with Sub Dural Hemorrhages
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
823X | | | | | | | | | | | |
| 19a. DATE OF OPERATION
4/27/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Depressed Temporal Area Skull | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
4/27/68 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 after 28a)
Driving Car that hit Telephone Pole. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office-building, etc.)
Street | | | 21f. LOCATION Street or R.F.D. No.
Providence Rd. & Cromwell Bridge | | | City or Town
County
State | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
5/2/68 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
May 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Riverview Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Wilmington, Del. | | | |
| 24. FUNERAL DIRECTOR
James Mullikin | | | | | | ADDRESS
James Mullikin, 2317 Market St., Wilm., Del. | | 25a. REC'D BY REGISTRAR
MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

Courtesy Card #129

26813

00213

STATE OF TEXAS

County of _____ State of _____

Know all men by these presents, _____ of the County of _____ State of _____

do hereby certify that _____ of the County of _____ State of _____

is the owner of the following described land, to-wit:

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7/68

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|------------------------|--|------------------|--|
| 06813 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 06820 | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Middle Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | |
| DAVID (ABRAHAM) STRAUSS | | | | 5 Month 20 Day 1968 | | 2:15 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | 9/25/95 | | 19 72 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| NEW JERSEY | | U.S.A. | | | | Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Randallstown, | | BALTO. CO. GEN. HOSP. | | MEAT CUTTER | | MANAGER | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| MD | | BALTO | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6952 Milbrook Park Dr | | Apt. 1 D | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Bernard Strauss | | Pearl ? | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| YES | | W.W. I | | MRS. MARY STRAUSS | | 6952 MILBROOK PK. DR, APT. 1-D | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | 4100 | | DUE TO, OR AS A CONSEQUENCE OF | | CARDIOGENIC SHOCK | | 12 hours | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | MYOCARDIAL INFARCTION | | 2 days | | | |
| | | (c) | | | | ASHD and HYPERTENSION | | many years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County | | State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17, 1968, to 5/20, 1968, that (I) (we) last saw the deceased alive on 5/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| Richard Katon M.D. | | 5/20/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| RICHARD KATON | | BALTO. CO. GEN. HOSP. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| BURIAL | | 5-22-68 | | OHR KNESSETH ISRAEL ANSHE | | SFARD, GERMAN HILL ROAD | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| SOL LEVINSON & BROS., | | 6010 REISTERSTOWN ROAD | | MAY 24 1968 | | J. J. Judge | | | | | |

00330

00330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
30M REV. 7-68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
ALVERTA MAE TAYLOR | | | 2a. DATE OF DEATH Month Day Year
5 18 68 | | | 2b. HOUR
3 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
CAU | | 5. DATE OF BIRTH
1/13/86 | | 6. AGE (In years lost birthday)
82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
BALTIMORE MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY Md. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREATER BALTIMORE CENTER MEDICAL HOUSE WIFE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3117 FERNDAL AVENUE | |
| 14. FATHER'S NAME First Middle Last
GEORGE BASEMAN | | | 15. MOTHER'S MAIDEN NAME First Middle Last
UNK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
215-03-8305 | | 17. INFORMANT
MRS. EARL KEATING | | Address
3117 FERNDAL AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>gastrointestinal hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cirrhosis of liver</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>5810 Atherosclerotic and hypertensive cardiovascular disease</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>68</u> , to <u>5/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R. Breitenecker MD. | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/19/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Rudiger Breitenecker MD | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-22-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Emory Methodist Cem | | 23d. LOCATION (City or Town) (County) (State)
Westminster, Maryland | | | |
| 24. FUNERAL DIRECTOR
Ellsworth Armacost-4600 Liberty Hgts. Ave | | | | 25a. REC'D BY REGISTRAR
MAY 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1828

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|---|--|---|---|-----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| CATHERINE | | | M. P. THOMPSON | | | MAY 7, 1968 | | 4:20 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| FEMALE | | WHITE | | DECEMBER 10, 1898 | | 69 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE, Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TOWSON | | | ST. JOSEPH HOSPITAL | | | HOMEMAKER | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | | | BALTO. | | | | 235 S. EAST AVE. #21224 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Frank Pitell | | | Anna Price | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 216-01-7848 | | Henry Thompson - 6506 S. Charter Rd. 21061 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>ACUTE MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (b) (this hospital) attended the deceased from <u>MAY 6</u> , 19 <u>68</u> , to <u>MAY 7</u> , 19 <u>68</u> , that (b) (we) last saw the deceased alive on <u>MAY 7</u> , 19 <u>68</u> , and that in (b) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| ISMAEL JAMORA, M.D. | | | | | 7620 YORK RD. TOWSON, MD. #21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | May 11, 1968 | | Holy Rosary | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| George A. Weber - 705 S. Ann St. - #21231 | | | | | MAY 8 1968 | | Charles Judge | | | |

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|-------------------------|---|---|---|---|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) Florence C. Thompson | | | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month May Day 20 Year 1968 | | 2b. HOUR M | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
3-6-90 | 6. AGE (In years last birthday)
77 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month 5 Day 20 Year 1968 | | 2d. HOUR M | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | |
| 10. CITY OR TOWN OF DEATH
Balto. Co. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Josephs Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1925 Edgewood Rd. 21234 | |
| 14. FATHER'S NAME
First John Middle Neasline Last Neasline | | | 15. MOTHER'S MAIDEN NAME
First Margaret Middle Creamer Last Creamer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
090 05 4257 | | 17. INFORMANT
Mrs. Margaret Monaghan, 1925 Edgewood Rd. | | ADDRESS 21234 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchitis Pneumonia 13 Days
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis 10+ yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c) Fracture of Rt Femoral Neck 13 Days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
450.0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE OF DEATH
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
5 P.M. May 7 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fell on Floor of own Home | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No.
1925 Edgewood | | City or Town
Baltimore | | State
Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | | ADDRESS (Street, city, town, or county)
21205 | | 22b. DATE SIGNED
5/20/68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City or Town)
Baltimore, Maryland | | (County) (State) | |
| 24. FUNERAL DIRECTOR
Johnson Funeral Home, 8521 Loch Raven Blvd. | | | | ADDRESS
21205 | | 25a. REC'D BY REGISTRAR
MA 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Judge | |

1

Florence G. Thompson

Female White 7-0-00

Weight/ane USA

Height/ane

St. Joseph's Hospital

Philadelphia

John

Residing

Married Green

90 25 1951 Mrs. Florence Thompson, 1951 Married

2-20-00

New England Cemetery

Philadelphia, Pa.

John Thompson, 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Hugh R. Titlow | | | | 2a. DATE OF DEATH
Month 5 Day 4 Year 68 | | | | 2b. HOUR
1:30 P.M. | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
Dec. 1, 1881 | | | | 6. AGE (In years lost birthday)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
personnel asst. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Univ. of Md. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4203 Van Buren Street | | |
| 14. FATHER'S NAME
First Charles Middle Titlow Last Titlow | | | | 15. MOTHER'S MAIDEN NAME
First ----- Middle ----- Last ----- | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
220-34-3279 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL Address HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) -----
DUE TO, OR AS A CONSEQUENCE OF
(c) ----- | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 9, 1968 , to May 4, 1968 that (I) (we) last saw the deceased alive on May 4, 1968 , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Vicente M. Ruelas MD DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
5-4-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
VICENTE M RUELAS MD | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/8/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National | | | | 23d. LOCATION (City or Town) (County) (State)
Suitland P. G. Md. | | | |
| 24. FUNERAL DIRECTOR
Lasch Funeral Home ADDRESS Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | | |

1830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06813

06825

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Florence Edna TREFE</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>22</i> Year <i>1968</i> | | | 2b. HOUR
<i>6:50</i> M | | |
| 3. SEX
<i>MALE</i> Female | | | 4. RACE
<i>CAU.</i> | | | 5. DATE OF BIRTH
<i>3/2/82</i> | | | 6. AGE (In years last birthday)
<i>86</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Baltimore</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Md.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>G.B.M.C.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>At Home</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Baltimore</i> | | | 13c. CITY OR TOWN
<i>BALTO</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
<i>212 Stanmore Rd.</i> | | | 14. FATHER'S NAME
<i>George F. Holmes</i> | | | 15. MOTHER'S MAIDEN NAME
<i>MARY Holmes</i> | | | 16. SOCIAL SECURITY NO.
<i>4100</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NA.</i> | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
<i>PT. O'Hart.</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiorespiratory insufficiency</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Subarachnoid hemorrhage (CVA)</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Hypertension</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>4201</i> | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | 22a. I certify that (I) (this hospital) attended the deceased from <i>5-15, 1968</i> , to <i>5-22, 1968</i> , that (I) (we) last saw the deceased alive on <i>5-22-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | |
| 22b. SIGNATURE
<i>Nasser Eftekhari</i> | | | 22c. DATE SIGNED
<i>5-22-68</i> | | | 22d. PHYSICIAN'S NAME (Type)
<i>Nasser Eftekhari M.D.</i> | | | 22e. ADDRESS
<i>GBMC Baltimore</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>5-27-68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Linden Park</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>BALTO Md.</i> | | |
| 24. FUNERAL DIRECTOR
<i>McColla</i> | | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 24 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

MEDICAL CERTIFICATION

31850

James L. Thompson

CRAC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06819

CERTIFICATE OF DEATH

06826

| | | | | |
|---|-----------------------------|--|---|--|
| 1. DECEASED-NAME
(Type or print) Louis (Luciano) Tringali | | 2a. DATE OF DEATH
Month 5 - Day 13 - Year 68 | | 2b. HOUR
12:12 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
1-20-99 | | 6. AGE (In years last birthday)
69 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
BALTO. CO. GEN. HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Owner - Fruit Stand |
| 12b. KIND OF BUSINESS OR INDUSTRY
Fruit | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET AND NUMBER
3722 Lochearn Dr. | | | | |
| 14. FATHER'S NAME
First Peter Middle Tringali Last Strazzula | | 15. MOTHER'S MAIDEN NAME
First Natiline Middle Strazzula Last Strazzula | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Wm. Rose Tringali Address 3722 - Lochearn Drive - Balto. Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetic Acidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebrovascular accident (Thrombosis)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13-68 , to 5-13-68 , that (I) (we) last saw the deceased alive on 5-13-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
V.R. Batoyon | | | | 22c. DATE SIGNED
5-13-68 |
| 22d. PHYSICIAN'S NAME (Type)
V. R. BATOYON | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
5/16/68 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | 23d. LOCATION (City or Town)
BALTO. | (County) MD (State) |
| 24. FUNERAL DIRECTOR
Leoring Byers | | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

REPUBLIC OF DENMARK

06813

06813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|-------------------------------------|--|--|--|---|--|--|-----------------------------|---|-----------------------------------|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Charles D Uhden | | | | | | 2a. DATE OF DEATH Month Day Year
5 14 68 | | | 2b. HOUR
8:40 AM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12-17-06 | | | 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Forest Haven Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Electrician | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
161 S Marley ST | | | |
| 14. FATHER'S NAME First Middle Last
Charles D Uhden | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Gansby | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
Yes | | | | 16b. SOCIAL SECURITY NO.
220-07-4848 | | 17. INFORMANT
Eugene Conn-NPN | | | | Address
315 Ingleside Ave. 21228 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY SCHEMATICALLY CLASH</u> | | | | | | | | | | | | | |
| 1428 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) <u>EMPHYSEMA - EMPHYSEMA</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) <u>PECP</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 1427 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-12-1967, to 5-14-1968, that (I) (we) last saw the deceased alive on 5-13-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
John Shaw MD | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/15/68 | |
| 22d. PHYSICIAN'S NAME (Type)
John Shaw MD | | | | 22e. ADDRESS
5800 Edmondson Ave. Catonsville, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cem. | | | | 23d. LOCATION (City or Town)
Balto. Md. | | (County) (State) | | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave. Balto. Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 16 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

MEDICAL CERTIFICATION

00330

STATE OF OHIO

00330

Received of the Treasurer of the State of Ohio, the sum of \$100.00

for the purchase of the State of Ohio, the sum of \$100.00

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06821

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06828

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--------|------------------------------|--|--|--|--|------|---------------------------|--|---|--|--|----------|-----|--|---|--|--|--|--|--|------------------------|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First | | | Middle | | | Last | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR | | | | | | | | | | | | | | |
| JOHN RALPH | | | WAGNER | | | | | | | | | 5 22 1968 | | | 12:15 | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year | | | 2d. HOUR | | | | | | | | | | | | | | |
| Male | | White | | 10-18-1905 | | 62 YRS. | | | | | | May 22 191968 | | | 12M | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Tenn. | | | | U.S. | | | | | | | | Baltimore | | | | Md. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Woodlawn | | | | | | 1822 Colmar Rd. | | | | | | State Hospital Attendant | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | 13b. COUNTY | | | | | | 13c. CITY OR TOWN | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | | | | Balto. | | | | | | Woodlawn | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 1822 Colmar Rd. | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | |
| David W Wagner | | | | | | Margaret B. Stout | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | ADDRESS | | | | | | | | | | | |
| Yes | | | | | | W.W. 11 | | | | | | 216 16 8660 | | | | | | Gladys L. Wagner 1822 Colmar Rd. 21207 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of the brain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 976X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| | | | | | | ? 522 19 68 | | | | | | Subject shot himself in the head | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| Home | | | | | | 1822 Colmar Rd. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | May 22, 1968 | | | | | | | | | | | | | | | | | |
| Edward F. Wilson, M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | |
| Burial | | | | | | 5-27-1968 | | | | | | Baltimore National | | | | | | Frederick Rd. Baltimore, Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Edu P. Mac Nally | | | | | | 301 Frederick Rd. 28 | | | | | | MAY 27 1968 | | | | | | Charles Judge | | | | | | | | | | | |

101 Frederick Rd. 25
Belmonte Harbor
Frederick Rd. 25
2-27-1952
Initial

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|-------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First
Patsy | | | Middle
B. | | | Last
Walker | | | 2a. DATE OF DEATH
Month
May | | | Day
20 | | | Year
1968 | | | 2b. HOUR P.
4:30 M. | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
Dec. 21, 1912 | | | 6. AGE (In years last birthday)
55 YRS. | | | IF UNDER 1 YEAR
MONTHS
55 | | | IF UNDER 24 HRS.
HOURS
55 | | | MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Rosedale | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1412 Spring Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Inspector | | | 12b. KIND OF BUSINESS OR INDUSTRY
Distillery Works | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Rosedale | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
1412 Spring Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME | | | First
Jasper | | | Middle
N. | | | Last
Dugger | | | 15. MOTHER'S MAIDEN NAME | | | First
Rachel | | | Middle
Sparks | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-22-8850 | | | 17. INFORMANT (Husband)
Mr. Earl W. Walker, 1412 Spring Ave. | | | Address
Rosedale, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable coronary occlusion | | | | | | | | | | | | | | | | | | | | | | | |
| 4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) severe arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4201 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 64 , to 5-20 , 19 68 , that (I) (we) lost the deceased alive on 4-30- 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
W. H. Townshend Jr. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | | | | 22c. DATE SIGNED
5/21/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
W. H. Townshend Jr. | | | 22e. ADDRESS
14 E. Eager St. Baltimore, Md. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
5/23/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print)
ANNA MAY WEBSTER | | | 2a. DATE OF DEATH
Month MAY Day 16 Year 1968 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
May 5, 1890 | | 6. AGE (In years
last birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
19D Montrose Manor Court | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Real Estate | | 12b. KIND OF BUSINESS OR
INDUSTRY
Self | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) "STATE"
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
19D Montrose Manor Court | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME First Middle Last
Bradford Rich | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna R. Amos | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) No (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
Mr. Albert Rich | | | Address
Ellicott City, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
4120
DUE TO, OR AS A CONSEQUENCE OF Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF Heart Failure (Chronic)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
443X | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1965 , to May 16, 1968 , that (I) (we) last saw the deceased alive on May 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dr. Paul L. Byerly | | | | 22c. DATE SIGNED
5/28/68 | | 22d. PHYSICIAN'S NAME (Type)
Dr. Paul L. Byerly | | | |
| 22e. ADDRESS
5820 York Rd. Baltimore, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Higinbotham-Slack Funeral Home | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|--|---|---|---|--|----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| HYMAN | | | LEWIS WEINBLATT | | | MAY 18 1968 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| MALE | | WHITE | | AUG 20, 1992 | | 75 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| RUSSIA | | U.S.A. | | | | BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTO | | | 3312 LEE CT | | | SALESMAN | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | BALTO | | BALTO | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3408 AVONDALE AVE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| HASKEL | | | ZELDA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | 214-05-3409 | | MRS MEYER OXMAN | | 3312 LEE CT | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 151.9 | | | | | | | | 1 yr | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 150x | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966 to May 18, 1968, that (I) (we) last saw the deceased alive on May 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Joseph B Gross | | | | | | | | | May 18/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| Joseph B Gross | | | | | 6911 Park Heights | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | May 19, 1968 | | Kneass Road Kell | | Balto Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Sydney S. Lainsa Son, Inc | | | | | 9610 Reservoir | | DATE MAY 21 1968 | | Charles Judge | |

1883

RECEIVED IN DEPT

1883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
EDWARD M. WEISS | | | | | 2a. DATE OF DEATH Month Day Year
5 25 68 | | | 2b. HOUR
4:50 P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
3/16/16 | | 6. AGE (In years lost birthday)
52 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
VILNA, GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREATER BALTIMORE MEDICAL CENTER | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
WATCHMAKING | | 12b. KIND OF BUSINESS OR INDUSTRY
JEWELER | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1630 INGRAM AVE. | |
| 14. FATHER'S NAME First Middle Last
MICHAEL WEISS | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ESTHER ISAACSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
MRS. LILLIAN WEISS - SAME | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE
4120
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
5 yr. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
443X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-22-68, to 5-25-68, that (I) (we) last saw the deceased alive on 5-25-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-25-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
[Name] | | | | | 22e. ADDRESS
GREATER BALTIMORE MEDICAL CENTER | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth T. Hill | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
[Signature] | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

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RECEIVED

55330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR X15 (4)
30M REV. 1/68

| 06826 | | | | | | | | | | 06833 | | | | | | | | | | | | | | |
|---|--|--|---------|--|--|------------------|--|--|--|--|---------------------------------|--|--|------------------------|---|--|------------------|--|--|------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | Item#16, Film#G401 6/3/68 km | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | |
| GRACE | | | | | S. WEITZEL | | | | | MAY 20, 1968 | | | | | 2:55 A M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | |
| FEMALE | | | WHITE | | | MAY 19, 1922 | | | | | 46 YRS. | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | |
| MARYLAND | | | | | U.S.A. | | | | | | | | | | BALTIMORE. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| TOWSON | | | | | ST. JOSEPH HOSPITAL | | | | | HOMEMAKER | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | |
| MARYLAND | | | | | Balto. | | | | | Towson | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 100 LESLIE AVE. #21236 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | |
| William F. Schwarz | | | | | Grace Conklin | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | |
| No | | | | | 166-11-11111 | | | | | William B. Weitzel | | | | | 100 Leslie Avenue | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON | | | | | | | | | | | | | | | | | | | | | | | | |
| 153.8 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) UNDETERMINED | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | |
| 153.8 | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from MAY 4, 1968, to MAY 20, 1968, that (X) (we) lost the deceased on MAY 20, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Arturo Q Santos M.D. | | | | | | | | | | | | | | | MAY 20, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| ARTURO SANTOS, M.D. | | | | | | | | | | | | | | | 7620 YORK ROAD TOWSON, MD. #21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | 5-23-1968 | | | | | Baltimore Nat'l Cemetery | | | | | Baltimore City Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Lassahn Funeral Home 7401 Belair Road 21236 | | | | | | | | | | DATE MAY 22 1968 | | | | | Charles Judge | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (2)
30M REV. 1-1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | |
|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) Harvey John Wellbrock | | 2a. DATE OF DEATH
Month May Day 30 Year 1968 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
July 15, 1908 | | 6. AGE (In years last birthday)
59 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Pikesville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7610 Seven Mile Lane | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Electrician | |
| 12b. KIND OF BUSINESS OR INDUSTRY
I.B.E.W. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Pikesville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET AND NUMBER
7610 Seven Mile Lane | | | | |
| 14. FATHER'S NAME First Middle Last
Frank Dickinson | | 15. MOTHER'S MAIDEN NAME First Middle Last
unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) none | | 16b. SOCIAL SECURITY NO.
067-05-7479 | | 17. INFORMANT Address
Mr. Robert Wellbrock, 7610 Seven Mile Lane |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cessation of Respiration
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) metastatic melanoma in the lungs
DUE TO, OR AS A CONSEQUENCE OF
(c) metastatic melanoma involving liver, lungs, bones, skin & brain
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)
163x | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/4/67 , 19 67 , to 5/22/68 , 19 68 , that (I) (we) last saw the deceased alive on 5/22/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Rouben M. Jiji, M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
6/1/68 |
| 22d. PHYSICIAN'S NAME (Type)
ROUBEN M. JIJI, M.D. | | 22e. ADDRESS
University Hospital, Balt. Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
June 3, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Cemetery | 23d. LOCATION (City or Town) (County) (State)
Randallstown Baltio. Md. | |
| 24. FUNERAL DIRECTOR
Frank H. Newell, Pikesville 8, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1968 | | 25b. REGISTRAR'S SIGNATURE
James J. Jones |

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UNITED STATES GOVERNMENT
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06823

06835

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Glenna L. Wells | | | 2a. DATE OF DEATH
Month May Day 6 Year 1968 | | | 2b. HOUR 11:30 MIN M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
October 27, 1884 | | 6. AGE (In years lost birthday)
83 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Springfield, Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Dulaney Towson Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
school teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Reisterstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
17 Aldyth Avenue | | 14. FATHER'S NAME
First Harmon Middle K. Last Wells | | 15. MOTHER'S MAIDEN NAME
First Laura Middle Gridley Last Wells | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address Belto 21204
Dulaney Towson Nursing Home, 111 West Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular accident.
4/20 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive arteriosclerosis C.V. disease 5 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes
3 yrs | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 min. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
443X Atherosclerosis.
8 yrs | | | | | | | |
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
none | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
none 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
none. | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
none. | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 5/6 , 19 68 , that (I) (we) last saw the deceased alive on 4/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
D.D. Catles MD | | | | 22c. DATE SIGNED
May 6/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
D.D. CATLES | | | | 22e. ADDRESS
6 HANOVER RD. REISTERSTOWN | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
May 9, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State)
Washington 18, D.C. | |
| 24. FUNERAL DIRECTOR
A.J. Schardt | | | | ADDRESS
Owings Mills, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 9 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> # 1 M </div> <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> <div style="text-align: right;"> 06829 06836 </div> | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--------------------------------|---------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First
MARY | | | Middle
E. | | | Last
WELLS | | | 2a. DATE OF DEATH
Month May Day 9 Year 1968 | | | 2b. HOUR
M | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
June 5, 1888 | | | 6. AGE (In years lost birthday)
79 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore County Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
6111 Raymond Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
8111 Raymond Avenue | | | | | | | |
| 14. FATHER'S NAME First Middle Last
William Hayes | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Catherine Rumble | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
216-18-4331 | | | 17. INFORMANT Address
Mrs. George Lorber 326 Carroll Island Rd | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5-8 mo | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 0 | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
none | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-27, 1968 , to 5/9, 1968 , that (I) (we) last saw the deceased alive on 5/8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Louis O. Olsen MD DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
5/10/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
LOUIS O. OLSEN MD | | | | | | 22e. ADDRESS
914 A St. - 2129 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
5-11-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore County, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 10 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

18838

CERIFICATE OF BIRTH

18838

Name: [illegible] Sex: [illegible] Date of Birth: [illegible]
 Place of Birth: [illegible]

Parents: [illegible]
 Address: [illegible]
 City: [illegible] State: [illegible]

Date of Issue: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|-----------------------------|---|------------------------------------|--|--|---|--|---|--|-----------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
William Robert Wheeler | | | | | | 2a. DATE OF DEATH Month Day Year
5 20 68 | | | 2b. HOUR P M
6:05 P | | |
| 3. SEX
male | | 4. RACE
caucasian | | 5. DATE OF BIRTH
5/11/84 | | | 6. AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GBMC Greater Balt. Medical | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Rate clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY
B & O R.R. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore Balto. | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
6 Center Road | | | |
| 14. FATHER'S NAME First Middle Last
Snowden Wheeler | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ida Clark | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
705-05-3123 | | | 17. INFORMANT Address
Wm. Ross Wheeler, Baltimore, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4360 Hypertensive Cerebral Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331A | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1952 to May 20 , 1968, that (I) (we) last saw the deceased alive on May 19 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Newland E. Day MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
May 20, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Newland E. Day, M.D. | | | | | | 22e. ADDRESS
4-E-33rd St Baltimore Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
May 23, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204 | | | | | | 25a. REC'D BY REGISTRAR
MAY 24 1968 DATE | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 06831 MARYLAND STATE DEPARTMENT OF HEALTH 06838 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print)
First <i>Chattye</i> Middle <i>R.</i> Last <i>White</i> | | | | | 2a. DATE OF DEATH
<i>May</i> Month <i>20</i> , Day <i>1968</i> | | | 2b. HOUR
M | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>October 1, 1883</i> | | 6. AGE (In years last birthday)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Port Royal Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Garrison</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Freleigh Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Glyndon</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>109 Central Ave.</i> | |
| 14. FATHER'S NAME First <i>Stephan</i> Middle <i>B.</i> Last <i>Rollins</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Susan</i> Middle <i>Gibbs</i> Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Mr. Sturman White</i> Address <i>Glyndon, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ruptured aortic aneurysm</i>
<i>441.9</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>451X</i>
(b) <i>Atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>18 mon.</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Cancer of the bladder & metastases</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>1966</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Hematuria</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>58</i> , to <i>20 May</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>16 May</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Douglas Lockard</i> | | | | M.D. DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>21 May, 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Dr. J. Douglas Lockard</i> | | | | 22e. ADDRESS
<i>Cockey's Mill Rd., Reisterstown, Md. 21136</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>May 23, 68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Druid Ridge Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Pikesville, Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>J. F. Eline & Sons</i> | | | | ADDRESS
<i>Reisterstown, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 22 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 06832 | | 06839 | | | | | | | |
| 1. DECEASED-NAME (Type or print) LILLIAN | | First M. Middle WICKER Last | | 2a. DATE OF DEATH
Month MAY Day 27 Year 1968 | | 2b. HOUR 4:30 MIN PM | | | |
| 3. SEX F | | 4. RACE White | | 5. DATE OF BIRTH
June 10, 1894 | | 6. AGE (In years last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County | | Md. | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor N. H. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 911 Huntsman Road | |
| 14. FATHER'S NAME First Henry Middle Rode Last | | 15. MOTHER'S MAIDEN NAME First Louisa Middle Gerke Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No | | 16b. SOCIAL SECURITY NO. 215-32-1051 | | 17. INFORMANT Mrs. Howard Barnes Address Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
431.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to MAY 27, 1968 , that (I) (we) last saw the deceased alive on 5/22 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE T.C. Swinski | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 27 MAY 68 | | | |
| 22d. PHYSICIAN'S NAME (Type) T.C. SWINSKI | | | | 22e. ADDRESS 206 W. PENNA. AV. TOWSON | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/31/68 | | 23c. NAME OF CEMETERY OR CREMATORY Western Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS 5305 Harford Rd. 21214 | | | | 25a. REC'D BY REGISTRAR MAY 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1998

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

• *Journal of Management Education* 25(1): 10-12

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06833

CERTIFICATE OF DEATH

06840

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| CHARLES | | WILHELM | | May | | Month 6 Day 1968 | | 5:10p | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | January 26, 1877 | | 91 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Germany | | U.S.A. | | Baltimore | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | | St. Joseph Hospital | | Retired Owner (Tavern) | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Baltimore | | Baltimore | | | | Cherry Ave. 5116 | | Pembroke Ave. 21206 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Anton | | Wilhelm | | Francisca | | Baumann | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 215-32-9655A | | Mr. Robert Wilhelm, Cheryl Ave. Kingsville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Septicemic shock</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>008.0</u> | | | | | | | | | | | |
| (b) <u>Escherichia Coli-organism</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>0533</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| <u>Congestive heart failure and pulmonary thrombo-embolism</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>68</u> , to <u>May 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Ines Cilliani, M.D.</u> | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 5-7-1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| | | St. Joseph Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 5/9/68. | | Holy Redeemer Cemetery | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Leonard J. Ruck, Inc. Balto. Md. 212 14 | | | | DATE MAY 7 1968 | | <u>Charles Judge</u> | | | | | |

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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) DENA WILL | | | First Middle Last | | | 2a. DATE OF DEATH
Month 5 Day 13 Year 68 | | 2b. HOUR
M | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
Feb. 5, 1875 | | 6. AGE (In years last birthday)
93 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Shangrila Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
4016 Hillcrest Ave. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
First Middle Last
----- Hohman | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
----- | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
William H. Will, 4016 Hillcrest Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
4379 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334x
(b) Aspiration
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral arteriosclerosis Inability to swallow
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Generalized Arteriosclerosis - recent amputation of leg due to gangrene
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-5-1967 , to 5-13-1968 , that (I) (we) lost the deceased alive on 5-13-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Cesar Valle Cervero | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-14-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO, M.D. | | 22e. ADDRESS
8629 Liberty Road | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-16-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Ritchie Hwy., A.A. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR George J. Gonce,
4001 Ritchie Hwy., Baltimore, Md. 21225 | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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UNITED STATES OF AMERICA

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WASHINGTON, D.C. 20540
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| <div>06835</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06842</div> | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|--------------------------|--|--|------------------|--|--|---------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First
Clifford | | | Middle
E. | | | Last
Williams Sr. | | | 2a. DATE OF DEATH
Month
May | | | Day
2 | | | Year
1968 | | | 2b. HOUR
M | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
March 31, 1919 | | | 6. AGE (In years
last birthday)
49 YRS. | | | IF UNDER 1 YEAR
MONTHS | | | IF UNDER 24 HRS.
DAYS | | | HOURS | | | MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
West Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore | | | | | | | | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Port Howard | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Avenue A | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Supervisor Bethlehem Steel Co. | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Ft. Howard | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Avenue A. | | | | | | | | | | |
| 14. FATHER'S NAME | | | First
Iver | | | Middle
D. | | | Last
Williams | | | 15. MOTHER'S MAIDEN NAME | | | First
Cecile | | | Middle
Porter | | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
Yes | | | (If yes give war or dates of service)
WWII | | | 16b. SOCIAL SECURITY NO.
218-05-1052 | | | 17. INFORMANT (Son)
Clifford E. Williams Jr. | | | Md. 21219 Address Rt. #10 Balto. | | | Box 161 Ave. B | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Diabetes mellitus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertensive Cardiovascular Disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 immediate
2 mo.
1 Year | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260x | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-24, 1968, to 3-3, 1968, that (I) (we) last saw the deceased alive on 4-2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John V. Conway, M.D. | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
May 3, 1968 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John V. Conway | | | M.D. | | | 22e. ADDRESS
914 "D" St. Sparrows Point, Md. 21219 | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
5/6/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE | | | MAY 6 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | |

MEDICAL CERTIFICATION

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CENTRAL OF DEATH

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MEDICAL CERTIFICATION

| MAY 15 1968 | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) First Louis Middle A. Last Williams | | | | | 2a. DATE OF DEATH Month May Day 12 Year 1968 | | | 2b. HOUR 8:40 ^A _M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 12/12/22 | | | 6. AGE (In years last birthday) 45 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY Fidelity & Deposit | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 7701 Windy Ridge Rd. | | 13f. #21236 | |
| 14. FATHER'S NAME First Middle Last Frank Williams | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lena Wright | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 219-18-5602 | | 17. INFORMANT Mrs. Myrtle Williams | | | Address 7701 Windy Ridge Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardio Respiratory Insufficiency
735.2
DUE TO, OR AS A CONSEQUENCE OF
Pulmonary atelectasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Severe kyphoscoliosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
745x Respiratory acidosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that 1 (this hospital) attended the deceased from May 8 , 19 68 , to May 12 , 19 68 , that 1 (we) last saw the deceased alive on May 12 , 19 68 , and that in 1 (my) (our) apinian death occurred on the date and hour and from the causes stated above. 1 (we) (did) 2000X view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. Orjuela Gomez, M.D. DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED May 12, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) R. Orjuela Gomez, M.D. | | | | | 22e. ADDRESS 7620 York Rd. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-15-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery | | 23d. LOCATION (City or Town) Baltimore (County) Co. (State) Md. | | | |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236 | | | | | 25a. REC'D BY REGISTRAR MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE J. Carlos Judge | | |

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Results:

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06837

CERTIFICATE OF DEATH

06844

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) EMORY RALPH WIMERT | | | 2a. DATE OF DEATH
Month MAY Day 16 Year 1968 | | | 2b. HOUR
9A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
9/18/1900 | | 6. AGE (In years last birthday)
67 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | |
| 10. CITY OR TOWN OF DEATH
Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
BEICK LAYER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
CAROLL | | 13c. CITY OR TOWN
WESTMINSTER | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
JOSEPH WIMERT | | 15. MOTHER'S MAIDEN NAME First Middle Last
AGNES UTZ | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) NA (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
220-03-5880 | | 17. INFORMANT Address
Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621 Carcinoma of the Lungs
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 163X Tuberculosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 10, 1968 to MAY 16, 1968 , that (I) (we) last saw the deceased alive on MAY 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
William Newcomer | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M.D. | | | | | | 22e. ADDRESS
Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Memorial Gardens | | 23d. LOCATION (City or Town) (County) (State)
Frederick, Carroll, Md. | |
| 24. FUNERAL DIRECTOR
John E. Myers Westminster, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

10044

75232

Ballentine County

William Henry, M.D., Wilson State Hospital

William Henry, M.D., Wilson State Hospital

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06838

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06845

| | | | | | | | | | | | | | | | | | |
|--|---------|------------------|--|---------------------------|---------------------------|--|--------------------------|--|--|----------------|--|--|-----------|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | | | |
| DOROTHY Streett | | | WISNOM | | | MAY 5/13 | | | 1968 | | | 7:30 P.M. | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | 7. IF UNDER 1 YEAR MONTHS | 8. IF UNDER 24 HRS. HOURS | 9. IF UNDER 24 HRS. MIN. | 2c. DATE PRONOUNCED DEAD | | | Month Day Year | | | 2d. HOUR | | | | |
| female | white | 1/10/1928 | 39 40 YRS. | | | | May 13, | | | 1968 | | | 8:30 P.M. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Glenarm | | | Kolt Farm Lane & Manor Rd. | | | Housewife | | | Home | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | | Baltimore | | | Glenarm | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Kolt Farm Lane & Manor Rd. | | | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | | | | | |
| Charles Howard | | | Streett | | | Emma Adelia | | | Whiteford | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMATION | | | 18. ADDRESS | | | | | | | | |
| No | | | --- | | | 215-56-5536 | | | Mrs. James H. Schumacher | | | 110 Stanmore Road Balto. Md. 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Massive Internal Bleeding due to Gunshot Wound | | | | | | | | | | | | | | | | | |
| 965X of Chest | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 981X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 7:30 P.M. 5/13 19 68 | | | subj. was shot in chest | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County State | | | | | |
| home | | | Glenarm, Baltimore, Maryland | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | 22b. DATE SIGNED | | | | | | | | | | | |
| Werner U. Spitz, M.D. | | | | | | 5/14/68 | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | |
| Burial | | | 5/16/1968 | | | William Watters Mem. Cooptown, Harford, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Charles E. Kurtz Jarrettsville, Md. | | | | | | MAY 16 1968 | | | | | | Charles Judge | | | | | |

3836

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 06838 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 06846 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Veronica F WOHLGEMUTH | | | 2a. DATE OF DEATH
Month Day Year
May 5, 1968 | | | 2b. HOUR
4:10 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
October 9, 1898 | | 6. AGE (In years last birthday)
69 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
713 Anneslie Rd. | | 14. FATHER'S NAME
First Middle Last
Thomas Fitzgerald | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bridget Kennedy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
George Wohlgemuth | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemoperi cardium with cardiac tamponade
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Impending myocardial rupture
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute posterior myocardial infarction
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4201 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/29/67 , to 5/5/68 , that (X) (we) last saw the deceased alive on 5/5/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Samuel Lee, M.D. | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-5-1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Samuel Lee, M.D. | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06840

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06847

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) CELESTE L. WOLFF | | | 2a. DATE OF DEATH
5 Month 25 Day 68 Year | | | 2b. HOUR
3:55PM | |
| 3. SEX
7 | | 4. RACE
W | | 5. DATE OF BIRTH
10/4/80 | | 6. AGE (In years last birthday)
87 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTO. | |
| 10. CITY OR TOWN OF DEATH
CATONSVILLE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SHANGRI-LA | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
26 DUNMORE RD. | | 14. FATHER'S NAME First Middle Last
AMOS J. GREGORY | | 15. MOTHER'S MAIDEN NAME First Middle Last
CELESTE G. NUNNALLY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
DOROTHY W. MANAHAN | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Brain Syndrome
4409 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr.
yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4500 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 52 , to May , 19 68 , that (I) (we) last saw the deceased alive on May 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Leo J. Gaver, M.D. | | | | 22c. DATE SIGNED
May 27, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Leo J. Gaver, M.D. | | | | 22e. ADDRESS
1 Mallow Hill Ave., Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY
LODOW PARK | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
E.S. MALNABB | | | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| CLARA ANNA WOLVERTON | | | | | | Month 5 Day 8 Year 68 | | | 8:30 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR |
| FEMALE | | CAUCASIAN | | 10-27-08 | | | 37 YRS. | | MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | | GBMC | | | OWNED FUNERAL HOME | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | |
| MARYLAND | | | BALTIMORE | | BALTIMORE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | XXXXXXXXXXXXX
204 East Joppa Rd. 04 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| LACEY MERIETH | | | NETTIE SULLIVAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 212-18-3761 | | Miss Doris Wolverson 204 E. Joppa Road #4 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> | | | | | | | | | |
| 4120 DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>Hypertension cardiovascular</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>cerebral thrombosis</u> | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 443X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-30-19-68</u> to <u>5-8-19-68</u> , that (I) (we) last saw the deceased alive on <u>7-15-8-19-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| <u>E. Soteman</u> | | | | | | | | 5-8-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| burial | | 5/11/68 | | Greenmount Mausoleum | | Balto., Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212 | | | | | MAY 13 1968 | | <u>Charles J. J...</u> | | |

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MINISTRE DU TRAVAIL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>06842</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06849</div> | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|-----------------------------------|---------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
GEORGE | | | Middle
WOODFORK | | | Last
WOODFORK | | | 2a. DATE OF DEATH
Month 5 Day 14 Year 68 | | | 2b. HOUR
3:10PM | | |
| 3. SEX
MALE | | | 4. RACE
NEGRO | | | 5. DATE OF BIRTH
4/13/1901 | | | 6. AGE (In years and day)
67 YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
507 W. Lafayette Avenue | | | | | |
| 14. FATHER'S NAME
First Warner Middle Woodfork Last Vestelia | | | 15. MOTHER'S MAIDEN NAME
First Jones Middle Jones Last Jones | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES (If yes give war or dates of service) WW I | | | 16b. SOCIAL SECURITY NO.
218 03 94 49 | | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER WITH LUNG METASTASIS
188X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1810 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (b) (this hospital) attended the deceased from 1/20/68 , 19____, to 5/14/68 , 19____, that (b) (we) lost the deceased alive on 5/14/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John D. Talbert, M.D. DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED
5/14/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | JOHN D. TALBERT, M. D. | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
5-17-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATL. | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS
MORTEN & DYETTE FUNERAL HOME | | | 25a. REC'D BY REGISTRAR
DATE
17 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |
| 1701 E. Laurens Street, Baltimore, Md. | | | | | | | | | | | | | | | | | |

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SAINTS' BROTHERS

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1. 1. 1.

216

DATE: 10/10/2001

1967-1968

SECRET

• • •

• ON GARDEN ST. (INTERSECTION AV.) RUMBLE, HIGGINS, 90 45 40 519

CAUTION: ONLY WHEN USED TO MONITOR

02/27/2

55-56

CHRYSLER CREDIT CORP.

U. S. DEPARTMENT OF COMMERCE

| Temperature (°C) | Rate of Polymerization (g/hr) |
|------------------|-------------------------------|
| 0 | 0.05 |
| 10 | 0.05 |
| 20 | 0.05 |
| 30 | 0.05 |
| 40 | 0.10 |
| 50 | 0.40 |
| 60 | 0.90 |
| 70 | 0.60 |
| 80 | 0.40 |

• **THESE** •

$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

1. *Phragmites australis* (Cav.) Trin. ex Steud.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
OM REV. 1/68

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|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--------------|--|--|--|--|---------------|--|--|--|--|
| 06843 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 06850 | | | | | | | | | | | | | | | | | | | |
| Item#13c&e, Film#G400 5/24/68km | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
Daisey | | | | | Middle
L. | | | | | Last
Wright | | | | | 2a. DATE OF DEATH
Month
May | | | | | Day
9 | | | | | Year
1968 | | | | | 2b. HOUR
M | | | | |
| 3. SEX
female | | | | | 4. RACE
white | | | | | 5. DATE OF BIRTH
Aug. 28, 1883 | | | | | 6. AGE (In years
last birthday)
84 | | | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Balto., Md. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Baltimore | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Baptist Home of Maryland | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
homemaker | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | | | 13b. COUNTY
Balto. | | | | | 13c. CITY OR TOWN
Owings Mills | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER
928 E. 31st St.
Park Heights Ave. extnd. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
William Leonhardt | | | | | Middle
Last | | | | | 15. MOTHER'S MAIDEN NAME
First
Thomas Ann Forster | | | | | Middle
Last | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown)
no | | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-22-6650 | | | | | 17. INFORMANT
Address
Baptist Home of Md. Owings Mills, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary sclerosis</u>
<u>4129</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral & generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>General Debility & dementia</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>64</u> , to <u>May 9</u> , 19 <u>68</u> , that (I) (we) lost
saw the deceased alive on <u>May 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. M. Paul Byerly</u> | | | | | | | | | | DEGREE
ATTENDING
PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>5/11/68</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Dr. M. Paul Byerly | | | | | 22e. ADDRESS
5820 York Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
burial | | | | | 23b. DATE
5/11/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | | | | 23d. LOCATION (City or Town) (County) (State)
Balto. Co. Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Mitchell-Wiedefeld Home 6500 York Road
Balto., Md. 21212 | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | | | | | | |

6236

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | |
|--|--|--------------|-----------------|--|--|--|--|---|----------------|-----------------------------------|--|---|--|---|---------------|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
EDWARD | | | Middle
R. | | | Last
ZAHNER | | | 2a. DATE KNOWN
OF
DEATH
MAY 13 1968 | | | 2b. HOUR
M | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
JULY 21, 1894 | | 6. AGE (In years
last birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | 2c. DATE PRONOUNCED DEAD
MAY 13 1968 | | | 2d. HOUR
M | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
MD. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
BALTO. | | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
812 REGISTER AVE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ARMACOST NURSING HOME | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
MACHINIST | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
CAN | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD | | | | 13b. COUNTY
BALTO | | | | 13c. CITY OR TOWN
ESSEX | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
712 RIVERSIDE DR. | | | | | |
| 14. FATHER'S NAME
First
JOHN
Middle
ZAHNER
Last | | | | | | 15. MOTHER'S MAIDEN NAME
First
MARY
Middle
SCHROLL
Last | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
UNK | | | | (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
151-01-0427 | | | | 17. INFORMANT
ED. A. ZAHNER | | | | ADDRESS
ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 5 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | | | City or Town
County
State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | | | | M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED
13 May 68 | | | | | | | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell, M.D. | | | | | | ADDRESS (Street, city, town, or county)
7501 YORK RD | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
MAY 16, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART | | | | 23d. LOCATION (City or Town)
BALTO. MD | | | | | | | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | | | | | ADDRESS
300 MACE | | | | | | 25a. REC'D BY REGISTRAR
MAY 16 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

any delay is
within 24 hours after death.
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06845

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06852

| | | | | | | | | | | | | | | | |
|---|--|------------------------------|-------------------|---|--|---|--|--|----------------|--------------------------------|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | Month Day Year | | | 2b. HOUR | | | |
| PHILIP | | | ZEITUNG | | | 5 26 19 | | | 688:00A | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | | |
| Male | | White | | 2-15-1968 | | YRS. 3 | | | | | | Month Day Year | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. COUNTY OF DEATH | | | |
| Balto. Md. | | U.S.A. | | | | | | | | | | Balto. Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Balto. | | | | 3651 Paskin Hillcrest Apt. Place #301 | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Md. | | | | Balto. | | | | Balto. | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | |
| Docton David | | | | Zeitung | | | | Patricia M. DeHaven | | | | Dr. David Zeitung 3651 Paskin Hillcrest Apts Balto. Md 21207 | | | |
| 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> (SDII)
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | 525X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY? | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | 22b. DATE SIGNED
May 26, 1968 | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | | | EDWARD F. WILSON, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 5/27/68 | | | | Woodlawn | | | | Woodlawn. Md | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR
DATE | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Kehring Syers | | | | 5728 Fibers Road,
Randallstown, Md | | | | MAY 31 1968 | | | | Charles Judge | | | |

85-03236

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UNITED STATES DEPARTMENT OF AGRICULTURE

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
FROM THE CHIEF, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
SUBJECT: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Mabel M. Zepp | | First Middle Last | | 2a. DATE OF DEATH
Month 5 Day 19 Year 68 | | 2b. HOUR a.m. 1:45 | |
| 3. SEX
Female | | 4. RACE
Caucasion | | 5. DATE OF BIRTH
11/29/1891 | | 6. AGE (In years lost birthday) 76 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BCGH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A Grocery Store | | 12b. KIND OF BUSINESS OR INDUSTRY N/A Owner | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodstock | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER Old Court Road | | 13f. ZIP 21163 | | | | | |
| 14. FATHER'S NAME First Robert Middle Myers Last Myers | | | | 15. MOTHER'S MAIDEN NAME First Idea Middle Zimmerman Last Zimmerman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | 16b. SOCIAL SECURITY NO. 220-36-0016 | | 17. INFORMANT Mr. Philip S. Zepp Jr. Address Old Court Road Woodstock, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ca of skull fracture & metastasis to brain
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-7 , 19 68 , to 5-19 , 19 68 , that (I) (we) lost the deceased alive on 5-19 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Isabelita G. Cordoba M.D. DEGREE M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 5/19/68 | |
| 22d. PHYSICIAN'S NAME (Type) ISABELITA CORDOBA, M.D. | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 22, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Longmeadow Park | | 23d. LOCATION (City or Town) (County) (State) Woodlawn Md. | |
| 24. FUNERAL DIRECTOR Louise Byers - 8728 S. Baltimore Ave. Randallstown Md. | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE MAY 22 1968 | |

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